

The 2011 Legislative Session In Review

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THE NEW FACES OF 2011



Jerry Brown - Governor



Senate Pro-Iem Steinberg &
Speaker Perez



Senate Health Chair Hernandez



Assembly Health Chair Monning



Diana Dooley – HHS Secretary



DMHC Director - Brent Barnhart

In General...

- 2011 was the first year of a two-year session with lots of freshman legislators and staff changes
- New Administration leadership at HHS, DHCS and DMHC
- Consumer Watchdog targeted health plans in a campaign to pass rate regulation with AB 52
- Several big bills were put over to next year or defeated, but then came SB 946...

The 2011 Session

Commenced: December 6th, 2010
Ended: September 9th, 2011
Veto Deadline: October 9th, 2011

Volume: There were over 2,700 bills introduced

Tracking: 210 health-related bills

Passage: 54 new health laws enacted

~~Vetoed: 8 bills vetoed by the Governor~~

The Big Issues in 2011

- Prospective health insurance rate review
- Medical loss ratio (MLR) implementation
- Creating the Health Benefits Exchange
- Several benefit mandates proposed – behavioral therapy for autism patients & PPO maternity benefit
- HIT: Telehealth & EMR audit records
- Prior authorization forms for pharmacy
- Impact of Open Primary & Redistricting

2010 Compared with 2011

2010

- Coverage Exchange created through SB 900 & AB 1602

- Premium Rate Review created through SB 1163

2011

- Exchange Board formed and CEO selected
 - Several meetings held
 - Final form of Exchange undetermined

- SB 1163 Ignored and AB 52 introduced early in the session

Health Benefit Exchange

The Board convened in 2011 and has met monthly to implement startup.

Five members, CEO is Peter Lee who started on 10/15

Board must commence operations by Q3 of 2013

Currently grappling with the eligibility portal

DMHC & OPA

SB 922 moves the Department of Managed Health Care under the Health & Human Services Agency (from BT&H) AB 922 (Monning)

- Increases OPA to cover all insureds in CA including Medi-Cal, HFP, Exchange, DOI etc. Expands OPA duties in consumer assistance, outreach, education, informing materials etc.
 - Clear signal that the DMHC will not be folded under the control of the Insurance Commissioner at the California Department of Insurance
 - Expect attempt in 2012 to legislate consolidation of regulatory functions within CDI – expect Governor to veto the bill if passed by the Legislature

Most implement on January 1, 2012

NEW HEALTH LAWS FOR 2012

SB 946: Behavioral therapy

- Mandates coverage for “Behavioral Health Treatments” by July 1, 2012.
- Requires plans to create an adequate network of autism providers.
- Requires coverage to be provided in the same manner and subject to the same requirements as the MHPA.
- Requires DMHC to convene an Autism Advisory Task Force by February 1, 2012.

SB 946: Overview

- Mandated benefit for full service plans and insurers.
- Sunsets July 2014.
- Benefits that exceed ACA Essential Benefits are not required.
- ~~Not required for state-funded programs (i.e., CalPers, Medi-Cal, Healthy Families) or~~

SB 946 - questions

- What is Behavioral Health Treatment?
- Professional services and treatment programs, including applied behavioral analysis, and evidenced-based intervention programs, that develop or restore functioning of an autistic individual.
- Prescribed by a physician or developed by a psychologist.
- Provided under a treatment plan.
- Rendered by qualified providers (parents cannot be reimbursed).

SB 946 - Implementation

- What are the requirements for treatment plans?
- Measurable goals over a specific timeline
- Reviewed periodically by provider
- Describe health impairments
- Service, hours, evaluations
- Use evidence-based practices with demonstrated clinical efficacy
- Discontinued when goals reached or appropriate
- Not used for purposes of respite, day care, or educational services.

SB 946 :Treatment Plans

- Who Provides Treatment?
- Plans must develop adequate networks which include:
 - Qualified autism service providers who supervise and employ qualified autism service professionals or paraprofessionals
- Plans can selectively contract with providers.

SB 946: providers

- Who Provides Treatment?
- Qualified autism service providers:
 - Person, entity or group that designs, supervises or provides treatment for pervasive developmental disorder or autism.
 - Is a licensed physician, PT, OT, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist; or
 - Is certified by a national entity that is accredited by the National Commission for Certifying Agencies

SB 946: who provides treatment

- Qualified autism service professional
 - Provides behavioral health treatment
 - Employed and supervised by a qualified autism service provider
 - Provides treatment pursuant to the treatment plan
 - Approved as a vendor by a California regional center
 - Has training and experience in providing services
- Qualified autism service paraprofessional
 - Unlicensed, uncertified individual
 - Employed and supervised by a qualified autism service provider
 - Provides treatment pursuant to treatment plan
 - Meets criteria of WI Code for paraprofessional
 - Has adequate education, training and experience as certified by the autism service provider

SB 866: Preauthorization forms

Standardized Prior Authorization Form

- Requires DMHC and DOI to jointly develop a uniform prescription drug prior authorization form, on or before July 1, 2012.
- Requires ALL health plans and insurers that provides a prescription drug benefit to use the standardized form, effective January 1, 2013 or 6 months after the form is developed, whichever is later.
- Requires form to:
 - Not exceed 2 pages;
 - Be made electronically available by DMHC and DOI;
 - May be submitted electronically to the plans;
 - Be develop with at least one public meeting; and
 - Take into account DHCS/CMS prior authorization forms and national standards on electronic prior authorization.

SB 866: Requirements

Response to Prior Authorization Request

- Requires health plans to respond to a complete prior authorization request within 2 business days (previously 5).
- If plans don't respond within the time allotted or fails to use or accept the standardized form, the request is deemed approved.
- Exempts Medi-Cal managed care which is subject to a 24 hour turnaround on prior authorization requests.

SB 866: Delegated groups

Exemptions

- Does not apply to physicians and physicians groups that have been delegated financial risk for prescription drugs and do not use a prior authorization process for prescription drugs (CAPG clause)
- Does not apply to a health plan or affiliated providers if the plan owns and operates its pharmacies and does not use a prior authorization process for prescription drugs

SB 866: Implementation

Plan Implementation Issues (courtesy of CAHP)

What does a standardized form look like?

Elements plans require to approve a PA request:

- Instructions to providers
- Patient information
- Prescribing physician information
- Prescription drug information
- Clinical Rational
- Inclusion of medical records?

What/ who defines "completeness"?

- Standard set by plan?
- What happens if the plan needs additional information? Stop the clock?

SB 866: Implementation

Response Time:

- Inclusion of the back and forth between providers?
- Take into account complexity of the case?
- No impact on plans adhering to the Medi-Cal 24hr standard in other lines of business.

Contract Amendments:

- Require providers to use uniform assessment.
- Require PBM to accept and authorize based on information provided.

SB 751 – Confidentiality Provisions

- Prohibits restrictions on providing plan enrollees information about:
 - Cost range of procedures
 - Quality
- Does not apply to delegated physician group contracts
- Still unclear what plans would be able to disclose publicly
- What is the appropriate risk adjustment factor?

SB 751 - Continued

- Plan obligations:
 - Provide 20 days advance opportunity to review methodology and data
 - Quality information must be risk-adjusted
 - Post a disclaimer regarding accuracy and relevance
 - Provide a link to the hospital's website responding to the information

SB 90/AB 113 – Comprehensive Budget Solution

- Three major components:
 - Six month hospital fee/IGT program
 - Reverse Medi-Cal payment reductions
 - Seismic safety deadline extension

SB 90/AB 113 – Comprehensive
Budget Solution

- Six month hospital fee/IGT program:
 - January 1 – June 30, 2011: \$858 million
 - IGT Program for public hospitals: \$80 million
 - \$210 million for children's healthcare coverage

SB 90/AB 113 – Comprehensive
Budget Solution

- Reverse Medi-Cal payment reductions:
 - 10% rate cut effective June 1, 2011
 - 2009 rate freeze
 - Retroactive restoration of CMAC 2009 rate freeze
 - 10%/CMAC-5% non-contracted Medi-Cal
- Reduce DSH replacement payments

SB 90/AB 113 – Comprehensive
Budget Solution

- Seismic safety deadline extension:
 - Authorizes OSHPD to grant seismic safety deadline extensions if certain requirements are met
 - Max: 7 years, no later than 2020
 - Three criteria:
 - Structural integrity of the building
 - Community access to essential hospital services
 - Financial capacity of the hospital to complete the project

AB1066:

- Five-year section 1115 Medicaid demonstration project: California's Bridge to Reform
- Implements the Low-Income Health Program (LIHP) – Medi-Cal, Healthy Families, AIM
- Uses mostly county funding to draw down FFP

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Hospital Operations

- AB 762: Permits commingling of sharps and non-pharmaceutical waste until they are treated by a common process
- SB 38: Extends the effective date of reporting requirements for patient radiation exposure
- SB 502: Posting of infant-feeding policy

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Post Acute Care Services

- AB 97: 10% rate reduction (really 25%) for skilled nursing; CMS approval required
- AB 574: Adds PACE as a Medi-Cal benefit
- AB 667: Updates medical necessity criteria for discharge to pediatric subacute care

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Health IT

AB 415: Sets "telehealth" standards - Expanded definition of telehealth, no longer excluding email and phone transmissions. Plans can not require in-person contact or limit setting of covered services provided via telehealth subject to terms and conditions of plan contracts. Applies to all plans including Med-Cal.

SB 24: conforms Calif. to HIPAA breach notice rule

SB 850: EMR systems must record user identities subject to federal rule to be eventually adopted

SB 945: authorizes HHS application for HITECH funds

SB 51 – Medical Loss Ratio

SB 51 will conform rate review to federal standards and require DMHC and CDI to develop regulations. The federal MLR regulation is nearing completion

The leftovers

Over 80 bills were placed on "two year" status:

AB 52 – Prior approval of premium increases

SB 393 – Medical Home definition

All bills re: implementation of the Exchange, awaiting federal rules to be issued

We are awaiting several key federal regulations this fall that will affect the 2012 legislative session

r.i.p.
DEFEATED BILLS

Governor Jerry Brown

- 2011
 - Signatures: 760
 - Vetoes: 128
 - Law w/o Signature: 1
 - Veto Rate: 14%

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Historical Veto Rates

- Arnold Schwarzenegger
 - Overall: 28.77%
 - Record High: 35.17% in 2008

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SB 791: Mammogram notice

Governor's Message: While I wholeheartedly support everyone's right to information about their own health, the notice in this bill gave me pause. I talked to many people, including doctors I respect, about the effects of the notice -- both its risks and benefits -- and struggled over the words. Were they a path to greater knowledge or unnecessary anxiety? My conclusion was this: every patient needs health information they can use. For women, that likely includes information about breast density. **But the notice contained in this bill goes beyond information about breast density. It advises that additional screening may be beneficial. If the state must mandate a notice about breast density -- and I am not certain it should -- such a notice must be more carefully crafted, with words that educate more than they prescribe.** I am returning Senate Bill 791 without my signature. Sincerely, Edmund G. Brown Jr.

aB 52: rate approval

Introduced just 80 days after the implementation date of SB 1168 on rate review because the prior bill had "failed" to curb health insurance rate increases!

Required prior approval of rates before new coverage could be issued, required 120 new hires

Gave the group Consumer Watchdog an

SB 538: board of Nursing

Governor's Message: I am returning Senate Bill 538 without my signature. The Board of Registered Nursing protects consumers and regulates professional nursing in California and this measure would extend the existence of this longstanding regulatory body until 2016. **Unfortunately, extraneous harmful provisions lurk within this otherwise benign sunset extension bill. These provisions would dramatically expand pension benefits for a select group of the Board's investigators. This makes no sense fiscally and flies in the face of much needed pension reform. It is unacceptable to jeopardize the extension of this Board's critical consumer protection role by allowing these provisions to be included in this otherwise simple sunset extension measure.** The Board has existed for 106 years without these enhanced benefits and should continue to do so. I would ask that as soon as it reconvenes, the Legislature send me legislation that both restores the Board of Registered Nursing and restores the provisions of law relating to "bureau status" for expired boards. In the interim, I direct my administration to take all actions necessary under the law to protect consumers and nurses alike until the Board is reconstituted in January. Sincerely, Edmund G. Brown Jr.

Other defeated bills

- Acupuncture (AB 72 Eng) – FAILED
- Mental Health Services (AB 154 Beall) – FAILED
- ABA Services (AB 171 Beall) – FAILED
- Prescription Drugs (AB 310 Ma) – FAILED
- Drugs: Step Therapy (AB 369 Huffman) – FAILED
- Fertility Preservation (AB 428 Portantino) – FAILED
- Screenings (AB 652 Mitchell) – FAILED
- Oral Chemotherapy (AB 1000 Perea) – FAILED
- Tobacco Cessation (SB 136 Yee) – FAILED
- ABA Services (SB 166 Steinberg) – FAILED
- Mammograms (SB 173 Simitian) – FAILED
- Breast Cancer (SB 255 Pavley) – FAILED
- Autism Services (SB 770 Steinberg) – FAILED

2011 isn't done just yet

- AB 52 Proponents may bring a ballot measure on prospective rate review
- Fall lobbying on Super Committee budget cuts to Medicare other federal programs
- Several anticipated regulations on health reform
- Formation of the California Health Benefits Exchange under CEO Peter Lee
- DMHC to begin new regulatory packages, starting with stakeholder meetings

Other Two-Year Bills

- Acupuncture (AB 72 Eng)
- Mental Health Services (AB 154 Beall)
- Prescription Drugs (AB 310 Ma)
- Drugs: Step Therapy (AB 369 Huffman)
- Fertility Preservation (AB 428 Portantino)
- Medi-Cal health assessment (AB 652 Mitchell)
- Oral Chemotherapy (AB 1000 Perea)
- Health Care Coverage (AB 1083 Monning)

What's In Store for 2012?

- Bigger, crazier election year than 2008!
- 40% of the Legislature will turn over
- Up to 10 new Congressional representatives, most from the Legislature
- MICRA push by Trial Lawyers?
- Effort to re-open Knox Keene FSSB regulations by consumer advocates over hospital risk assumption

Thank You!

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