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2018 Annual Conference
"Celebrating 20 Years of Collaboration"

**2018 ANNUAL LEGISLATIVE &
REGULATORY SUMMARY**

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OVERVIEW


- 2018 Elections
- Leadership Changes
- Congressional Action & ACA Litigation
- Single-Payer
- Rate Regulation
- Opioids/Prescription Drugs
- Mandates

2


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2018 ELECTIONS



3




Democrats:
 ✓ Governor
 ✓ Lt. Governor
 ✓ Secty. of State
 ✓ Ins. Comm.
 ✓ Treasurer
 ✓ Attorney Gen.
 ✓ Controller
 ✓ Sup. Of Education
 ✓ 28 State Senators
 ✓ 55+ Assm. Members

Republicans:
 ✓ 12 Senators
 ✓ -25 Assm. Members

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SENATE PRO TEM CHANGE




Toni Atkins

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8

SENATE HEALTH CHAIR CHANGE



Richard Pan, MD

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6

Congressional Actions & ACA Litigation



- The Tax Cut and Jobs Act of 2017
 - Reduced the penalty/tax for failing to maintain insurance to zero.
 - The bill didn't eliminate the individual mandate penalty/tax. Instead, it just set it at zero. This distinction is important because it means that a future Congress can adjust the levy upward in a general revenue or tax bill rather than attempt to reinstate the mandate itself in a healthcare or omnibus bill.
- Texas v. Azar
 - In Texas v. Azar, 20 states have sued the federal government, claiming that the individual mandate is unconstitutional.



SINGLE PAYER LEGISLATION STALLED



- Single payer legislation (SB 562) passed the Senate but was held in the Assembly this past year
- A political alternative was considered and enacted under State Budget Legislation (AB 1810) to create a Council on Health Care Delivery Systems to review future models to achieve universal coverage for all Californians under a single, unified system. That same budget legislation also authorized the creation of an all-payer claims database at OSHPD within the next 3 years, to support any future system
- Additionally, AB 2472 (Wood) requires the Council to prepare a feasibility analysis on the creation of a public health insurance plan option (Public Option) to increase choice and competition for health care consumers. The analysis must be complete by October, 2021

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PROVIDER RATE REGULATION STALLED



- AB 3087 (Kaira) would have created a new, independent state agency to oversee the development of provider fee-for-service rates. Providers would have had to seek approval from this Commission to increase their rates
- The bill also included complex provisions on the oversight of capitated payment and alluded to indexing it to Medicare Advantage

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MERGERS & ACQUISITIONS

AB 595 (Wood)

- Gives the Department of Managed Health Care, a State agency with jurisdiction over all HMO business the authority to:
 - Conduct public hearings on health plan mergers with other entities
 - New standards for the consideration of mergers, such as whether they will produce lower health care premiums, or increase competition in the market
 - New authority to deny mergers that don't present increased value to the market
 - Becomes effective on January 1, 2019



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10

PHARMACY BENEFIT MANAGERS

The Department of Managed Healthcare will register PBM's under a new law, AB 315 (Wood)	The law imposes a duty of good faith and fair dealing in the performance of contractual relationships	Disclosure of conflicts of interest to purchasers
Disclosure of drug acquisition rebates and rates negotiated with pharmacies upon a purchaser's request	Contract provisions preventing the disclosure of cheaper alternative drugs or prices for the same drugs are void as against public policy	The bill becomes effective on January 1, 2019



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11

DRUG COSTS

- AB 1860 (Limón)
- Copays and Coinsurance limits for prescribed, oral anticancer drugs will be limited to \$250 per month
- Applies to all HMO and PPO plans in California, but not to self-insured employer plans (ERISA)
- Becomes effective for plan renewals after January 1, 2019 and sunsets on January 1, 2024



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12

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DRUG COSTS

- AB 2863 (Nazarian)
- Pharmacists must inform a customer whether the retail price for a prescribed drug is lower than the applicable member cost-sharing amount
- Prohibits health plans from requiring copays or coinsurance amounts if the drug cost is lower than the applicable cost-sharing amount
- Becomes effective January 1, 2019

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13

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DRUG CAP

- SB 1021 (Wiener) Prohibits a health plan with regard to combination antiretroviral drug treatments that are medically necessary for prevention of AIDS/HIV, from having utilization management policies which relies on a multitablet drug regimen instead of a single-tablet drug regimen.
- Unless, consistent with clinical guidelines and peer-reviewed scientific and medical literature, the multitablet regimen is clinically equal or more effective and more likely to result in adherence to a drug regimen.
- Sunsets this provision on January 1, 2023.

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14

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PRESCRIBER REQUIREMENTS

- AB 2789 (Wood)
- All prescribers must be capable of electronic prescribing by January 1, 2022
- All prescriptions for controlled substances shall be transmitted electronically by January 1, 2022

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PREScriBER REQUIREMENTS


- ❑ AB 2086 (Gallagher) All prescribers of controlled substances shall be allowed to review a Department of Justice list of patients for whom they are listed as being the prescriber under the CURES Database Access
- ❑ Becomes effective on January 1, 2019

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16

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STATE OF EMERGENCY




- ❑ Under AB 2941, Health plans will be required to provide enrollees displaced during a declared state of emergency with access to medically necessary health care services
- ❑ Must file a plan within 48 hours describing how existing services have been impacted, how they will compensate, how they will communicate with enrollees, and how they will ensure continuity of care
- ❑ Relaxes time limits for authorizations, precertification or referrals
- ❑ Extends filing deadlines for claims
- ❑ Suspends prescription refill limitations, and includes out-of-network pharmacies
- ❑ Allows access to out-of-network providers
- ❑ Requires a toll-free telephone number for enrollee assistance with problems

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HEALTH PLAN OVERSIGHT



- ❑ AB 2674 (Augiar-Curry) requires the Department of Managed Healthcare to review provider-generated complaints about unfair payment patterns on an annual basis
- ❑ Authorizes DMHC to conduct a special audit or enforcement action
- ❑ Becomes effective on July 1, 2019

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18

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NETWORK ADEQUACY

Current Knox Keene Law requires 1 primary care physician for each 2,000 enrollees and 1 physician for every 1,200 enrollees. Prior legislation enacted in 2013 enabled a practice utilizing supervised, nonphysician medical practitioners to increase that ratio by an additional 1,000 lives. That legislation had a sunset provision.

⇒

SB 997 (Monning) eliminates the sunset provision and makes the expansion of physician to enrollee ratio permanent. Nonphysician medical practitioners are defined as a physician assistant, certified nurse-midwife, or a nurse practitioner.

⇒

Thus, the bill enables small practices to greatly increase their value to managed care plans by adding significant additional capacity to the plan's network.

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19

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DISCHARGE OF HOMELESS PATIENTS

- ❑ SB 1152 – Hospitals must have a written homeless discharge planning policy and process.
- ❑ Offer meals, clothing, transportation, vaccinations, follow-up referrals.
- ❑ Written plan for coordinating with county and private social services agencies.

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SEISMIC SAFETY 2020 STANDARD

- AB 2190 – Over 90% of hospital buildings meet the safety standard.
- Most hospital building renovations/new construction will meet the 2020 deadline.
- Limited extension for projects underway that have been subject to construction delays.
- Next Phase: 2030 Requirements.

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21

SCOPE OF PRACTICE: MEDICAL
LAB TECHNICIANS



- AB 2281 – Skilled health care workforce shortage – Clinical Laboratory Scientists.
- Critical in rural and underserved urban areas.
- Allows Medical Laboratory Technicians to perform additional tests.

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HOSPITAL LICENSING APPLICATIONS



- AB 2798 – Experiencing significant delays in regulatory approval of facility and equipment licensing applications.
- Impact of delays: Reduces access to health care services and increases costs.
- Hospital licensing fees have increased 103 percent in four years.
- Bill requires applications to be acted upon within 100 days or deemed approved for 18 months.

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23

RISK BEARING ORGANIZATION
REGULATION




- DMHC regulation still under development, but will likely implement the following:
- Greater transparency of complex relationships between plans and delegated physician groups
- RBOs are capitated physician groups that are delegated administrative functions by the plan, such as downstream claims payment of other providers, like ER services
- Will require higher amounts of capital to be infused into the RBO as a reserve and less reliance on sponsoring organizations, AR's, and IBNR
- Will require quarterly rather than annual compliance filings for smaller RBOs
- New filing forms that require greater detail on financial operations

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NON-CONTRACTED PROVIDER PAYMENT




AB 72 and the subsequent regulation established a new standard for payment of non-contracted providers of non-emergent, facilities-based services to covered enrollees. This law banned patient balance billing for these services



A default payment rate of no less than 125% of the applicable Medicare Fee Schedule (typically applies to radiology and pathology)



An average contracted rate methodology by the plan or delegated RBO based on the final DMHC regulation (typically applies to anesthesiology)



A dispute resolution program operated by the DMHC in Sacramento to resolve payment disputes over the amount of the "average contracted rate."

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HEALTH PLAN LICENSURE

- ❑ A regulation to formally establish the "Restricted License" in the Knox Keene Act – which includes Primecare, one of the original "Limited Licensees"
- ❑ RKKs, as they are referred to, accept global capitation from a fully-licensed health plan (both hospital and professional cap) and are fully-regulated by the DMHC, unlike RBOs, which are just monitored by the Department
- ❑ There has been a growing number of applications for RKK licenses and the Department wanted to formalize the process under regulation
- ❑ The Department redefined "global risk" as broader than just hospital and professional capitation, to other kinds of global payments that are not capitated, and the industry does not understand how this will work
- ❑ The regulation may affect non-capitated ACOs in Medicare, and commercial HMO and PPO ACOs – it is uncertain at this time

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26

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2019 LEGISLATIVE PREVIEW

- ❑ New Administration
- ❑ Single Payer /Universal Coverage
- ❑ Cost Containment
- ❑ MCO Tax
- ❑ Mandates
- ❑ Provider Relation Issues

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27

THANK YOU!

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28
