LEGISLATIVE UPDATE

Alliance of Catholic Health Care

Week of January 15, 2018

State Issues	
Budget Update: LAO Analysis	This week, the Legislative Analyst's Office released its assessment of the recently released Governor's January proposed budget. They commended the Governor for his proposal to focus on building greater reserves via our rainy-day fund, but advise the Legislature to set their own priorities and their own determination about the necessary amount we need in reserves to withstand the next recession. While they make no specific judgment about the Governor's proposals to fully fund education and allocate additional resources for community colleges and career technical education, they do note that his proposals for additional spending in infrastructure projects should be examined for their expanding costs in future budgets and for determining if they are the correct priorities. Of particular note in health care, and of serious concern to health care advocates, the LAO highlights that the Governor's budget does not allocate any of the funding collected from Proposition 55 for the Medi-Cal program. In 2016, voters passed Proposition 55, which extended tax rate increases on high-income Californians past in previous years. Proposition 55 includes a budget formula that is set to go into effect this budget year. This formula aims to provide up to $2 billion of additional funding each year for the Medi-Cal program when General Fund revenues exceed constitutionally required spending for schools and the "workload budget" costs of government programs that were in place as of January 1, 2016. The Administration is claiming, without further explanation included in the materials, that there is a $1.9 billion deficit in the funding for the workload budget. As a result, the Governor does not provide any of those additional resources to Medi-Cal. These funds were anticipated to provide additional funding for our private safety net hospitals, as well as earmarks for emergency care, mental health acute care, rural hospital care, and public and district hospitals. If you recall, this is a similar tactic the Governor used in recent years to divert the funding expected for Medi-Cal providers stemming from the passage of the Tobacco Tax. With a great deal of advocacy over time, the Governor has restored much of that funding for Medi-Cal providers. Health Care advocates are gathering more information on the proposal, and are strategizing about the best way forward. Click here to access the LAO's full report.
Select Committee on Health Care Reform	This week, the Assembly Select Committee on Health Care Delivery Systems and Universal Coverage had hearing chaired by Assemblymembers Dr. Jim Wood and Dr. Joaquin Arambula. This third in a series of hearings designed to explore best practices on achieving universal health care coverage focused on access to care, the provider networks and overall cost of care. The hearing was titled "Achieving better Access and Greater Value in California's Health Care System." You can access a video recording of the full hearing here: http://calchannel.granicus.com/MediaPlayer.php?view_id=7&clip_id=5138 You can access all of the materials, including the slide presentations of each panelist here: http://healthcare.assembly.ca.gov/content/2017-2018-hearings *(more)*

Select Committee on Health Care Reform *(continued)*	As in hearings past, the testimony was provided by academicians and nonprofit research organizations. Larry Levitt of the Kaiser Family Foundation focused some of his testimony providing a broad overview of the current system of care focusing on the concerns with fragmented care. Several panelists discussed access to health care and coverage. Sabrina Corlette of the Georgetown University Health Policy Institute focused her testimony on the insurance options under the Affordable Care Act and in our Covered California. Chris Perrone of California Health Care Foundation covered the access to care for adults in our Medi-Cal program, and highlighted the lack of adequate provider networks in the system. Janet Coffman, UCSF School of Medicine, covered more broadly the physician workforce and discussed the lack of diversity and the aging health care provider population. She also discussed the role of nurse practitioners, and the lack of adequate support for medical students in achieving their education. John Graves of Vanderbilt, focused on health insurance churn – when a policyholder moves from one health care system to another frequently because of changes in life circumstances, like job loss and employer sponsored coverage to wage increases that then make individuals ineligible for Medi-Cal. Larry Levitt lead off another panel focusing on understanding and addressing high prices. He provided an overview of the cost of administering health care in California for both hospitals and physicians. Erin Trish from USC focused on variations in provider payments in both the public and private insurance markets for practitioners and hospitals. Laurence "Loren" Baker from Stanford university discussed the variances in cost and prices and the reasons and role of consolidation in health plans and hospitals throughout the state. He says the research shows that physician, hospital, and physician-hospital consolidation leads to higher costs, while health plan consolidation leads to lower costs. This was of interest from Dr. Arambula who asked follow-up questions about what changes in current policy were needed to address this issue. Betsy Imholtz with Consumers Union and Jen Flory with Western Center on Law and Poverty provided a consumer perspective on these issues, and focused on the difficulty in accessing health insurance due to cost and the challenges that arise when having to move from health plan to plan and system to system for patients' continuity of care. Public testimony, as in past hearings, was dominated by representatives of the California Nurses Association, sponsors of SB 562, the single payer health care bill authored by Senator Ricardo Lara. Some of the CNA representatives took the opportunity to chastise Speaker Rendon and the Committee members for not focusing more on the single payer bill and calling it up for a vote. In addition, the California Medical Association testified regarding the lack of sufficient providers in the network. They mentioned the need for additional funds for loan repayment programs, additional state-only funding for graduate medical education and additional residency slots in non-traditional health care locations, like community clinics. The representative from the Services Employee International Union advocated for the legislature to focus on cost containment and price regulation. Cal Labor Fed touted their work on SB 17 last year, which will require price transparency from drug manufacturers and said they may need to go farther to price regulation through additional legislation. While not yet set, we are hearing another hearing of the Select Committee is being considered in February with the single payer bill being the focus.
New Report on Health Care Costs	The California Health Care Foundation recently published a report titled, "Health Care Costs 101: Spending Rose with More Coverage and Care." Of note, they state that the national health care spending growth slowed in 2016, which was due in part to decelerated growth in enrollment and decreased spending on prescription drug. *(more)*

New Report on Health Care Costs	Their *Health Care Costs 101* series of reports, which relies on the most recent data available, details how much is spent on health care in the US, which services are purchased, and who is paying for what. Key findings include: ▪ Prescription drug spending slowed significantly, increasing by 1.3% in 2016, compared to 8.9% in 2015. The decrease was due, in part, to lower spending for drugs used to treat hepatitis C. ▪ Federal government spending grew 3.9% ($35 billion) in 2016, slower than spending by business and households. ▪ Out-of-pocket spending increased by 3.9% in 2016, faster than the 2.8% increase in 2015, partially due to increased cost sharing for those with private insurance. ▪ Per capita health spending increased by 3.5%, down from 5.0% in 2015. CHCF created a fascinating infographic depicting costs over the years, which could be found here: http://www.chcf.org/publications/2017/09/data-viz-hcc-national. You can find the full report here: http://www.chcf.org/publications/2017/09/health-care-costs-101.
Federal Issues	
HHS Announces New Conscience and Religious Freedom Division	On Thursday morning, January 18, 2018, the U.S. Department of Health and Human Services (HHS) announced the formation of a new Conscience and Religious Freedom Division in the HHS Office for Civil Rights (OCR) - see link here. The announcement took place at an event held in HHS's auditorium. Speakers included Acting HHS Secretary Eric D. Hargan, House Majority Leader Kevin McCarthy (R-CA), Representative Vicky Hartzler (R-MO), Senator James Lankford (R-OK), OCR Director Roger Severino, and special guests. The Conscience and Religious Freedom Division was established to restore enforcement of federal laws that protect the rights of conscience and religious freedom. OCR is the law enforcement agency within HHS that enforces federal laws protecting civil rights and conscience rights in health and human services, and the security and privacy of people's health information. The creation of the new division will enable HHS to more vigorously enforce existing federal laws protecting the rights of conscience and religious freedom, the first freedom protected in the Bill of Rights. OCR already has enforcement authority over federal conscience protection statutes, such as the Church, Coats-Snowe, and Weldon Amendments; Section 1553 of the Affordable Care Act (on assisted suicide); and certain federal nondiscrimination laws that prohibit discrimination on the basis of religion in a variety of HHS programs. The new OCR division will be investigating violations of conscience rights, such as the California Department of Managed Health Care's (DMHC's) August 2014 private health insurance abortion mandate. The mandate required private market health insurers to amend their plans to cover all abortions, including late-term and gender selective abortions. The mandate does not include an exemption for employers who conscientiously object to covering and paying for non-therapeutic abortions. Click here to view a copy of the DMHC mandate letter to Aetna.