LEGISLATIVE UPDATE

Alliance of Catholic Health Care

Week of May 13, 2019

State Issues	
Legislative Hearings Update	Both houses held their Appropriations Suspense hearings this week, and several hundred bills were dispensed with – either moving on to the Floor for a vote of the full body or made into two-year bills to potentially move next year. Many of the bills that passed through the Committees were amended without prior notice or the opportunity to review, so in several cases, we are still studying the amendments and working to understand the implications to the bill and our position. Included below is an overview of some of the key bills we are working on that saw action yesterday in Appropriations. • ***AB 4 (Bonta)*** and ***SB 29 (Durazo)*** remove eligibility barriers to full-scope Medi-Cal for low-income undocumented adults. Both bills made it out of Appropriations, but both were amended to only have them go into effect if they have sufficient budget allocations to implement them. As you know, the Governor has held that these proposals simply cost too much money, and he continues to stand by his proposal to have Medi-Cal expanded to undocumented residents through age 25. This issue will now move to the budget negotiations between the Governor and the Legislature. • **AB 174 (Wood)/SB 65 (Pan)** are two bills that provided additional state supports to families buying coverage through Covered California. While both bills passed through the Appropriation process, Dr. Wood's AB 174 was amended to only be implemented if there is a subsequent budget appropriation. Dr. Pan's bill made it through without any amendments. • **AB 414 (Bonta)/SB 175 (Pan)** institutes a state-only insurance mandate. The goal is to help ensure stability in the individual market and prevent premium spikes. While the individual mandate was eliminated at the federal level last year, this is California's attempt to institute it here. The Assembly Chair indicated the bill may be amended to phase out the bill should the federal mandate be reinstated, but that amendment is not yet in print. Both bills passed through Committee. • **AB 204 (Wood),** which requires hospitals to separately report their community benefit data passed the Assembly Appropriations Committee. It was amended to add in a $5000 fine for hospitals that refuse to comply, exclude marketing costs from community benefits definition, and exclude district hospitals. The section of the bill that calculates the value of charity care using a percentage of Medicare allowable rates remains in the bill and will continue to be opposed by the hospital community. • **AB 329 (Rodriguez)** makes an assault on hospital personnel on hospital grounds a criminal offense and would allow hospitals to post certain notices. The bill passed out of Appropriations without amendment and the Alliance will continue to support it through the Legislative process. (*more)*

Legislative Hearings Update *(continued)*	• **AB 962 (Burke),** would require certain hospitals to submit a report to the state on their support of businesses owned by minorities, women, veterans, or lesbian, gay, bisexual, or transgender (LGBT) individuals. The bill passed the Committee, and the hospital community will continue to seek amendments as it moves through the process. • **AB 1611 (Chiu)** would prohibit patients from being balanced bill when receiving care in a noncontracted hospital and set the rate the hospital can be reimbursed. This bill passed out of Committee with amendments to exclude doctors and nurse practitioners and to include a payment rate of "reasonable and customary." However, because the bill continues to reference an average contract rate, the hospital community will continue to oppose the bill. • **SB 66 (Atkins)** is designed to improve access to mental health services in FQHCs and RHCs by allowing those facilities the ability to charge for a visit when the behavioral health visit is the second of the day. The bill passed the Appropriations Committee on a unanimous, bi-partisan vote and will next head to the Senate Floor. • **SB 260 (Hurtado)** will require health plans and insurers to help minimize gaps in coverage for individuals who often move between Covered CA and Medi-Cal. The bill passed Appropriations on a 4-2 vote. • **SB 612 (Pan),** which would require Kaiser Permanente to adhere to the same or similar oversight requirements as other health plans was held in Senate Appropriations and is now a two-year bill. The next few weeks will have our advocacy focused on these and our other key bills moving their way through their respective Floor votes, we will also be working with the state budget as the debate moves from the Subcommittees to the full budget committees before the Conference Committee is named to work through all the differences. The Legislature has just under a month to finalize their budget bills and get them to the Governor's desk by the June 15 deadline.
Legislative Summary and Status Report	Attached is the most recent Alliance Legislative Summary and Status report on bills of interest to the Catholic health care ministry.
Federal Issues	
Surprise Billing Hearings Continue	This week, the House Energy and Commerce Committee released a bipartisan "discussion draft" of legislation to protect patients from "surprise" medical bills – *see attached summary and discussion draft legislation*. The No Surprises Act, authored by Chairman Frank Pallone (D-NJ) and ranking member Greg Walden (R-OR) would require that patients be notified and give their consent before scheduled care is delivered by an out-of-network provider. Patients not told in advance would be protected from high medical bills. One provision would settle payment disputes by creating a minimum payment standard targeted at the median contracted, in-network rate for a service in a geographic area. However, states would still be able to set their own payment standards for health plans they regulate. The discussion draft also includes $50 million in grants for states looking to develop or maintain an all payer claims database. Meantime, the House Ways and Means Committee separately announced that it would hold a hearing on surprise billing next week. As reported earlier, the House Education and Labor Committee held a hearing in February.

Alliance of Catholic Health Care
Legislative Summary and Status 5/17/2019

Access / Health Care Reform

AB 4 **(Bonta D) Medi-Cal: eligibility.**
Location: 5/16/2019-A. SECOND READING
Summary: Federal law prohibits payment to a state for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Current law requires that individuals under 19 years of age enrolled in restricted-scope Medi-Cal at the time the Director of Health Care Services makes a determination that systems have been programmed for implementation of these provisions to be enrolled in the full scope of Medi-Cal benefits, if otherwise eligible, pursuant to an eligibility and enrollment plan, which includes outreach strategies. This bill would extend eligibility for full-scope Medi-Cal benefits to individuals of all ages, if otherwise eligible for those benefits, but for their immigration status, and would delete provisions delaying eligibility and enrollment until the director makes the determination as specified

Position
Support

AB 174 **(Wood D) Health care coverage: financial assistance.**
Location: 5/16/2019-A. SECOND READING
Summary: Would require the board, contingent on an appropriation in the 2019–20 Budget Act, to administer enhanced premium assistance to individuals with household incomes below 400% of the federal poverty level, reduce premiums to zero for individuals with household incomes at or below 138% of the federal poverty level, reduce premiums for individuals with household incomes at or between 401% and 800% of the federal poverty level and who are ineligible for federal advanced premium tax credits so their premiums do not exceed a specified percentage of their household incomes, and administer specified additional cost-sharing financial assistance for individuals with household incomes below 400% of the federal poverty level and who are eligible for premium tax credits. The bill would authorize the board to proportionally reduce enhanced premium assistance if the projected cost for a fiscal year exceeds the amount appropriated in the Budget Act for that fiscal year. If the federal government reduces or eliminates funding for the advanced premium tax credit, the bill would end the administration of enhanced premium assistance 6 months after that change in federal funding.

Position
Support

AB 414 **(Bonta D) Healthcare coverage: minimum essential coverage.**
Location: 5/16/2019-A. APPR. SUSPENSE FILE
Summary: Current federal law, the Patient Protection and Affordable Care Act (PPACA), enacts various healthcare coverage market reforms as of January 1, 2014. PPACA generally requires individuals, and any dependents of the individual, to maintain minimum essential coverage, as defined, and, if an individual fails to maintain minimum essential coverage, PPACA imposes on the individual taxpayer a penalty. This provision is referred to as the individual mandate. This bill would require a California resident to ensure that the resident and the resident's dependents are covered under minimum essential coverage for each month beginning after 2019. The bill would impose a penalty for the failure to maintain minimum essential coverage.

Position
Support

SB 29 **(Durazo D) Medi-Cal: eligibility.**
Location: 5/16/2019-S. APPR. SUSPENSE FILE
Summary: The federal Medicaid program provisions prohibit payment to a state for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Current law requires individuals under 19 years of age enrolled in restricted-scope Medi-Cal at the time the Director of Health Care Services makes a determination that systems have been programmed for implementation of these provisions to be enrolled in the full scope of Medi-Cal benefits, if otherwise eligible, pursuant to an eligibility and enrollment plan, which includes outreach strategies. This bill would extend eligibility for full-scope Medi-Cal benefits to individuals of all ages who are otherwise eligible for those benefits but for their immigration status, and would delete provisions delaying implementation until the director makes the determination as specified.

Position
Support

SB 65 **(Pan D) Health care coverage: financial assistance.**
Location: 5/16/2019-S. THIRD READING
Summary: Would require the California Health Benefit Exchange, only to the extent that the Legislature appropriates funding for these purposes, to administer a program of financial assistance, to be known as the Affordable Care Access Plus Program, to help low-income and middle-income Californians access affordable health care coverage with respect to individual coverage that is made available through the Exchange. The bill would require the program to provide financial assistance to California residents with household incomes below 600% of the federal poverty level, and would authorize the program to provide other appropriate subsidies designed to make health care more accessible and affordable for individuals and households.

Position
Support

SB 66 **(Atkins D) Medi-Cal: federally qualified health center and rural health clinic services.**
Location: 5/16/2019-S. THIRD READING
Summary: Current law provides that federally qualified health center (FQHC) services and rural health clinic (RHC) services, as defined, are covered benefits under the Medi-Cal program, to be reimbursed, to the extent that federal financial participation is obtained, to providers on a per-visit basis. "Visit" is defined as a face-to-face encounter between a patient of an FQHC or RHC and specified health care professionals, including a physician and marriage and family therapist. Under existing law, "physician," for these purposes, includes, but is not limited to, a physician and surgeon, an osteopath, and a podiatrist. This bill would authorize reimbursement for a maximum of 2 visits taking place on the same day at a single location if after the first visit the patient suffers illness or injury requiring additional diagnosis or treatment, or if the patient has a medical visit and a mental health visit or a dental visit, as defined.

Position
Support

SB 175 **(Pan D) Health care coverage: minimum essential coverage.**
Location: 5/16/2019-S. THIRD READING
Summary: Would create the Minimum Essential Coverage Individual Mandate to require a California resident to ensure that the resident, and any dependent of the resident, is covered under minimum essential health coverage, as defined, for each month beginning on January 1, 2020, except as specified. The bill would require the Exchange to grant exemptions from the mandate for reason of hardship or religious conscience, and would require the Exchange to establish a process for determining eligibility for an exemption.

Position
Support

SB 260 **(Hurtado D) Automatic health care coverage enrollment.**
Location: 5/16/2019-S. THIRD READING
Summary: Would require the Exchange, beginning no later than July 1, 2020, to enroll an individual in the lowest cost silver plan or another plan, as specified, upon receiving the individual's electronic account from a county, or upon receiving information from the State Department of Health Care Services regarding an individual terminated from department-administered health coverage. The bill would require enrollment to occur before Medi-Cal coverage or coverage administered by the State Department of Health Care Services is terminated, and would prohibit the premium due date from being sooner than the last day of the first month of enrollment.

Position
Support

Behavorial Health

AB 43 **(Gloria D) Mental health.**
Location: 5/16/2019-A. SECOND READING
Summary: Current law authorizes the Mental Health Services Act (MHSA) to be amended by a 2/3 vote of the Legislature if the amendments are consistent with, and further the intent of, the act. Current law authorizes the Legislature to add provisions to clarify procedures and terms of the act by majority vote. This bill would clarify that the planning process for innovative programs is to be completed in collaboration with stakeholders and is to comply with open meetings laws.

Position
Watch

AB 563 **(Quirk-Silva D) Mental health: funding.**

Location: 5/1/2019-A. APPR. SUSPENSE FILE

Summary: Would appropriate $16,000,000 from the General Fund to the State Department of Health Care Services to distribute to the North Orange County Public Safety Task Force for the development of a 2-year pilot program. The bill would require 1/2 of the moneys to be distributed on January 1, 2020, and 1/2 to be distributed on January 1, 2021, and would require the moneys to be used to provide a range of programs, services, and activities designed to assist individuals and families experiencing mental health crises. The bill would require the task force to submit a report to the Legislature by July 1, 2021, and again by July 1, 2022, documenting the findings and outcomes of the pilot program.

Position
Watch

AB 682 **(Eggman D) Health facilities: residential mental health or substance use disorder treatment.**

Location: 4/3/2019-A. APPR. SUSPENSE FILE

Summary: Would require the State Department of Public Health, in consultation with specified entities, to develop and submit a proposal to solicit a grant under the federal 21st Century Cures Act to develop a real-time, Internet-based database to collect, aggregate, and display information about the availability of beds in inpatient psychiatric facilities, crisis stabilization units, residential community mental health facilities, and licensed residential alcoholism or drug abuse recovery or treatment facilities for treatment purposes.

Position
Watch

AB 1055 **(Levine D) Publicly funded technology projects.**

Location: 4/25/2019-A. RLS.

Summary: Would require a public agency undertaking a publicly funded major technology project that is estimated to cost $100,000,000 or more to form an oversight committee subject to the Ralph M. Brown Act or the Bagley-Keene Open Meeting Act, as applicable, and to develop and use risk management plans throughout the course of the project. The bill would require the oversight committee to be composed of specified members selected by the public agency undertaking the project. The bill would require the oversight committee to act as the authority for critical decisions regarding the project and to have sufficient staff to support decision making.

Position
Watch

AB 1572 **(Chen R) Mental health services: gravely disabled.**

Location: 3/14/2019-A. HEALTH

Summary: Current law, for the purposes of involuntary commitment and conservatorship, defines "gravely disabled." This bill would change the definition of "gravely disabled" for these purposes to read, in part, a condition in which a person, as a result of a mental health disorder, is incapable of making informed decisions about, or providing for, the person's own basic personal needs for food, clothing, shelter, or medical care without significant supervision and assistance from another person and, as a result of being incapable of making these informed decisions, the person is at risk of substantial bodily harm, dangerous worsening of a concomitant serious physical illness, significant psychiatric deterioration, or mismanagement of essential needs that could result in bodily harm.

Position
Pending Review

SB 596 **(Stern D) Mental health.**

Location: 2/22/2019-S. RLS.

Summary: The Lanterman-Petris-Short Act provides for the involuntary commitment and treatment of a person who is a danger to themselves or others or who is gravely disabled. Current law requires a person who receives evaluation or treatment pursuant to the act to be given a choice of physician or other professional person providing those services, in accordance with the policies of each agency providing those services, and within the limits of available staff in the agency. This bill would instead make that provision applicable to a person receiving both evaluation and treatment under the act.

Position
Pending Review

SB 640 **(Moorlach R) Mental health services: gravely disabled.**

Location: 4/26/2019-S. 2 YEAR

Summary: Tthe Lanterman-Petris-Short Act provides for the involuntary commitment and treatment of a person who is a danger to themself or others or who is gravely disabled. This bill would change the definition of "gravely disabled" for these purposes to read, in part, a condition in which a person, as a result of a mental health disorder, is incapable of making informed decisions about, or providing for, the person's own basic personal needs for food, clothing, or shelter without significant supervision and assistance from another person and, as a result of being incapable of making these informed

decisions, the person is at risk of substantial bodily harm, dangerous worsening of a concomitant serious physical illness, significant psychiatric deterioration, or mismanagement of the person's essential needs that could result in bodily harm.

Position
Pending Review

Hospital Operations and Finance

AB 149 **(Cooper D) Controlled substances: prescriptions.**
Location: 3/11/2019-A. CHAPTERED
Summary: Current law classifies certain controlled substances into designated schedules. Current law requires prescription forms for controlled substance prescriptions to be obtained from security printers approved by the department, as specified. Current law requires those prescription forms to be printed with specified features, including a uniquely serialized number. This bill would delay the requirement for those prescription forms to include a uniquely serialized number until a date determined by the Department of Justice that is no later than January 1, 2020. The bill would require, among other things, the serialized number to be utilizable as a barcode that may be scanned by dispensers.

Position
Support

AB 389 **(Santiago D) Substance use disorder treatment: peer navigators.**
Location: 4/26/2019-A. 2 YEAR
Summary: Would require the State Department of Health Care Services to either establish a pilot program or expand an existing pilot program for purposes of measuring the efficacy and cost avoidance of utilizing trained substance use disorder peer navigators and behavioral health peer navigators in the emergency department of an acute care hospital, as described, if Funds for this purpose are appropriated in the annual Budget Act. The bill would provide that an acute care hospital may be eligible to receive funding under the pilot program to fund peer navigator positions.

Position
Watch

AB 714 **(Wood D) Opioid prescription drugs: prescribers.**
Location: 5/16/2019-S. B., P. & E.D.
Summary: Current law requires a prescriber, as defined, to offer to a patient a prescription for naloxone hydrochloride or another drug approved by the United States Food and Drug Administration for the complete or partial reversal of opioid depression when certain conditions are present, including if the patient presents with an increased risk for overdose or a history of substance use disorder, and to provide education on overdose prevention to patients receiving a prescription and specified other persons. This bill would make those provisions applicable only to a patient receiving a prescription for an opioid or benzodiazepine medication, and would make the provisions specific to opioid-induced respiratory depression, opioid overdose, opioid use disorder, and opioid overdose prevention, as specified.

Position
Watch

AB 774 **(Reyes D) Health facilities: reporting.**
Location: 5/1/2019-S. HEALTH
Summary: Current law requires hospitals to file an Emergency Care Data Record for each patient encounter in a hospital emergency department with the Office of Statewide Health Planning and Development. Current law requires the record to contain specified patient and health data information, including the service date and the disposition of the patient.This bill would additionally require the report, until January 1, 2027, to include the time of registration and the date and time of admission, transfer, or discharge, as well as the location of the discharge or transfer, including the name of the facility, if applicable.

Position
Watch

AB 844 **(Irwin D) Health facilities: mandated hospital services and activities.**
Location: 4/26/2019-A. 2 YEAR
Summary: Current law, until July 1, 2020, requests that the University of California to establish the California Health Benefit Review Program to assess legislation proposing to mandate a benefit or service of a health care service plan or health insurer or proposing to repeal an existing mandated benefit or service of a health care service plan or health insurer. Current law requests that the university provide that analysis to the appropriate policy and fiscal committees of the Legislature not

later than 60 days after receiving a request for the analysis. This bill would establish an independent, nonpartisan body to advise the Governor and Legislature on the financial impact of proposed mandated hospital services and activities.

Position
Support

AB 910 **(Wood D) General acute care hospitals: consolidated licensing.**
Location: 4/26/2019-A. 2 YEAR
Summary: Would require the State Department of Public Health, on or before January 1, 2021, to report to the Legislature the name, location, and license identification of every general acute care hospital operating under a single consolidated license that operates 2 or more physical plants located more than 15 miles apart. The bill would further require the department, on or before January 1, 2022, and annually thereafter, to update the report, as specified. The bill would also make technical changes to these provisions.

Position
Pending Review

AB 962 **(Burke D) Hospitals: procurement contracts: disclosures.**
Location: 5/16/2019-A. APPR. SUSPENSE FILE
Summary: Would require a licensed hospital with operating expenses of $25,000,000 or more to annually submit a report to the office on its minority, women, LGBT, and veteran-owned business enterprise procurement efforts, as specified. The bill would require each report to be submitted on July 1, 2020, and then annually thereafter. The bill would impose specified civil penalties for a failure to submit that report. The bill would require the office to maintain a link on the office's internet website that provides public access to the content of those reports, as specified.

Position
Watch

AB 1014 **(O'Donnell D) Health facilities: notices.**
Location: 5/14/2019-S. RLS.
Summary: Current law requires a hospital that provides emergency medical services to, as soon as possible, but not later than 90 days prior to a planned reduction or elimination of the level of emergency medical services, provide notice of the intended change to the department, other specified entities, and the public. Current law requires a health facility implementing a downgrade or change to make reasonable efforts to ensure that the community it serves is informed of the downgrade or closure. Current law also requires a health facility to provide public notice, as specified, not less than 30 days prior to closing the facility, eliminating a supplemental service, as defined, or relocating the provision of supplemental services to a different campus. This bill would require a hospital that provides emergency medical services or a health facility to provide notice, as specified, at least 180 days before making the changes described above.

Position
Watch

AB 1404 **(Santiago D) Department of Managed Health Care: Financial Solvency Standards Board.**
Location: 5/9/2019-S. DESK
Summary: Current law establishes, within the Department of Managed Health Care, the Financial Solvency Standards Board, which is comprised of the director of the department and 7 members, appointed by the director. Current law authorizes the 7 appointed members to be from specified subject areas or fields, including, but not limited to, medical and health care economics, accountancy, with experience in integrated or affiliated health care delivery systems, and management and administration in integrated or affiliated health care delivery systems. This bill would add 2 appointed members to the board. The bill would also include large group health insurance purchasing and a representative of health care consumers in the list of subject areas or fields from which the director may choose board members.

Position
Watch

AB 1495 **(O'Donnell D) Hospitals: seismic safety.**
Location: 4/26/2019-A. 2 YEAR
Summary: Would specify that if a hospital submitted a seismic compliance plan based on a removal plan, but also submitted a timely seismic compliance plan or plans based on one or more of the other methods of seismic compliance, the extension may be granted for the seismic compliance plan or plans based on the methods other than the removal plan.

Position
Watch

AB 1544 **(Gipson D) Community Paramedicine or Triage to Alternate Destination Act.**
Location: 5/16/2019-A. SECOND READING
Summary: Would establish within the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act until January 1, 2030, the Community Paramedicine or Triage to Alternate Destination Act of 2019. The bill would authorize a local EMS agency to develop a community paramedicine or triage to alternate destination program, as defined, to provide specified community paramedicine services. The bill would require the authority to develop regulations to establish minimum standards for a program and would further require the Commission on Emergency Medical Services to review and approve those regulations.

Position
Watch

AB 1611 **(Chiu D) Emergency hospital services: costs.**
Location: 5/16/2019-A. SECOND READING
Summary: Would require a health care service plan contract or insurance policy issued, amended, or renewed on or after January 1, 2020, to provide that if an enrollee or insured receives covered services from a noncontracting hospital, the enrollee or insured is prohibited from paying more than the same cost sharing that the enrollee or insured would pay for the same covered services received from a contracting hospital. The bill would require a health care service plan or insurer to pay a noncontracting hospital for emergency services rendered to an enrollee or insured pursuant to a specified formula, would require a noncontracting hospital to bill, collect, and make refunds in a specified manner, and would provide a dispute resolution procedure if any party is dissatisfied with payment.

Position
Oppose Unless Amend

AB 1630 **(Irwin D) Medical billing task force.**
Location: 4/26/2019-A. 2 YEAR
Summary: Would require OSHPD, in consultation with the Insurance Commissioner, to establish a medical billing task force on or before April 1, 2020. The bill would require the task force to, among other things, engage interested parties in the development of a system to improve the readability of medical bills and create a standard medical billing form. The bill would require OSHPD, on or before December 1, 2020, to submit a report to the Legislature on the task force's efforts.

Position
Watch

SB 343 **(Pan D) Healthcare data disclosure.**
Location: 5/6/2019-A. DESK
Summary: Would eliminate alternative reporting requirements for a plan or insurer that exclusively contracts with no more than 2 medical groups or a health facility that receives a preponderance of its revenue from associated comprehensive group practice prepayment health care service plans and would instead require those entities to report information consistent with any other health care service plan, health insurer, or health facility, as appropriate. The bill would also eliminate the authorization for hospitals to report specified financial and utilization data to OSHPD, and file cost data reports with OSHPD, on a group basis.

Position
Pending Review

SB 758 **(Portantino D) Hospitals: seismic safety.**
Location: 5/14/2019-S. THIRD READING
Summary: The Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983 requires, before January 1, 2020, the owner of an acute care inpatient hospital whose building does not substantially comply with described seismic safety regulations or standards to submit to the office an attestation that the board of directors of that hospital is aware that the hospital building is required to meet a specified deadline for substantial compliance with those regulations and standards. This bill would require, on or before January 1, 2021, the owner of an acute care inpatient hospital to update the above-described submission by reporting the services provided in each building of the acute care inpatient hospital.

Position
Support

Not for Profit

AB 204 **(Wood D) Hospitals: community benefits plan reporting.**

Location: 5/16/2019-A. SECOND READING
Summary: Would require the Office of Statewide Health Planning and Development, no later than July 1, 2020, to develop regulations to standardize the calculation of the economic value of community benefits and community benefit plan reporting, as specified. The bill would require the office, upon implementation of the regulations, to annually prepare a report on community benefits, as specified, and post the report and the community benefit plans submitted by the hospitals on its internet website. The bill would authorize the office to impose fines not to exceed $5,000 on hospitals that fail to adopt, update, or submit community benefit plans. The bill would authorize the office to grant an extension under these provisions, as specified. This bill contains other related provisions.

Position
Pending Review

Social Determinants of Health

AB 816 **(Quirk-Silva D) California Flexible Housing Subsidy Pool Program.**
Location: 5/8/2019-A. APPR. SUSPENSE FILE
Summary: Would establish the California Flexible Housing Subsidy Pool Program within the Department of Housing and Community Development for the purpose of making grants available to applicants, defined to include a city, county, city and county, or continuum of care, for eligible activities including, among other things, rental assistance, operating subsidies in new and existing affordable or supportive housing units, and specified outreach services. The bill would continuously appropriate $450,000,000 from the General Fund every fiscal year to the department for purposes of the program, and set forth how these funds must be allocated.

Position
Pending Review

Workforce

AB 329 **(Rodriguez D) Hospitals: assaults and batteries.**
Location: 5/16/2019-A. APPR. SUSPENSE FILE
Summary: Would make an assault committed on the property of a public or private hospital punishable by imprisonment in a county jail not exceeding one year, by a fine not exceeding $2,000, or by both that fine and imprisonment. By expanding the scope of a crime, this bill would impose a state-mandated local program.

Position
Support

AB 890 **(Wood D) Nurse practitioners: scope of practice: unsupervised practice.**
Location: 5/15/2019-A. APPR. SUSPENSE FILE
Summary: Would establish the Advanced Practice Registered Nursing Board within the Department of Consumer Affairs, which would consist of 9 members. The bill would authorize a nurse practitioner who holds a certification as a nurse practitioner from a national certifying body recognized by the board who practices in certain settings or organizations to perform specified functions without supervision by a physician and surgeon, including ordering and interpreting diagnostic procedures, certifying disability, and prescribing, administering, dispensing, and administering controlled substances.

Position
Support

SB 227 **(Leyva D) Health and care facilities: inspections and penalties.**
Location: 5/16/2019-A. HEALTH
Summary: Current law specifically requires the State Department of Public Health to adopt regulations that require a general acute care hospital, an acute psychiatric hospital, and a special hospital to meet minimum nurse-to-patient ratios and assign additional staff according to a documented patient classification system for determining nursing care requirements. Current law also generally requires the department to periodically inspect every health facility for which a license or special permit has been issued for compliance with state laws and regulations. This bill would require the periodic inspections of these specified health facilities to include reviews of compliance with the nurse-to-patient ratios and staff assignment regulations described above.

Position
Oppose

SB 567 **(Caballero D) Workers' compensation: hospital employees.**

Location: 4/26/2019-S. 2 YEAR

Summary: Would define "injury," for a hospital employee who provides direct patient care in an acute care hospital, to include infectious diseases, cancer, musculoskeletal injuries, post-traumatic stress disorder, and respiratory diseases. The bill would create rebuttable presumptions that these injuries that develop or manifest in a hospital employee who provides direct patient care in an acute care hospital arose out of and in the course of the employment. The bill would extend these presumptions for specified time periods after the hospital employee's termination of employment. The bill would also make related findings and declarations.

Position
Oppose

SB 697 **(Caballero D) Physician assistants: practice agreement: supervision.**

Location: 5/16/2019-S. THIRD READING

Summary: Would remove the requirement that the Physician Assistant Board make recommendations to the Medical Board of California concerning the formulation of guidelines for the consideration and approval of applications by licensed physicians and surgeons to supervise physician assistants. The bill, except as specified, would remove the limit on the number of physician assistants that a physician and surgeon may supervise.

Position
Watch

Total Measures: 37
Total Tracking Forms: 37

DISCUSSION DRAFT FOR COMMENT
Released by Chairman Pallone and Ranking Member Walden
House Energy and Commerce Committee
May 14, 2019

The No Surprises Act

American families need relief from the problem of surprise medical bills, that are leaving families across the country with crippling amounts of financial debt. Chairman Pallone and Ranking Member Walden have begun the process of addressing this critical consumer issue by releasing a discussion draft of the *No Surprises Act.* Specifically, the draft would:

Prohibit surprise medical bills and hold patients harmless in emergency situations

- Patients are at their most vulnerable when they experience a medical emergency and simply have no ability to consider whether a provider is in-network or out-of-network.
- The *No Surprises Act* prohibits balance billing for all emergency services and patients would only be held responsible for the amount they would have paid in-network.

Increase transparency and empower patient choice

- Even the most educated consumers have a hard time navigating our healthcare system. It is critical that providers, hospitals, and insurers all do a better job of helping patients understand their health insurance coverage.
- The *No Surprises Act* requires that patients receiving scheduled care be given written and oral notice at the time of scheduling about the provider's network status and any potential charges they could be liable for if treated by an out-of-network provider.
- If a patient does not sign a consent form acknowledging that the provider is out-of-network the patient can not be balance billed.

Prohibit surprise medical bills from providers that patients cannot reasonably choose

- Patients receiving scheduled care should be fully notified about whether providers are in or out of their network; however, in some cases notice is not practical.
- There are far too many stories of consumers scheduling care with an in-network provider only to later get hit by a bill from a facility-based provider they did not choose.
- The *No Surprises Act* prohibits balance bills from providers patients cannot reasonably choose.

Establish a market-based benchmark to resolve out-of-network payment disputes between providers and insurers

- Payment disputes between providers and insurers must be resolved in a manner that takes the patient out of the middle, is transparent and does not increase federal healthcare expenditures.
- The *No Surprises Act* establishes a minimum payment standard set at the median contracted (in-network) rate for the service in the geographic area the service was delivered. It also preserves a state's ability to determine their own payment standards for plans regulated by the state.

Encourage the development of state all-payer claims databases

- State based all-payer claims databases have the potential to shine a light on healthcare costs and spur innovative policy solutions.
- The *No Surprises Act* provides $50 million in grants for states looking to develop or maintain an all-payer claims database.

[DISCUSSION DRAFT]

116TH CONGRESS
1ST SESSION

H. R. _____

To amend the Public Health Service Act and title XI of the Social Security Act to protect health care consumers from surprise billing practices, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

Mr. PALLONE (for himself and Mr. WALDEN) introduced the following bill; which was referred to the Committee on _____

A BILL

To amend the Public Health Service Act and title XI of the Social Security Act to protect health care consumers from surprise billing practices, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''No Surprises Act''.

SEC. 2. PREVENTING SURPRISE MEDICAL BILLS.

(a) EMERGENCY SERVICES PERFORMED BY NONPARTICIPATING PROVIDERS.—Section 2719A of the Pub-

lic Health Service Act (42 U.S.C. 300gg–19a) is amended—

(1) in subsection (b)—

(A) in paragraph (1)—

(i) in the matter preceding subparagraph (A)—

(I) by striking ''offering group or individual health insurance issuer'' and inserting ''offering group or individual health insurance coverage''; and

(II) by inserting ''or, for plan year 2021 or a subsequent plan year, with respect to services in an independent freestanding emergency department (as defined in paragraph (2)(C))'' after ''emergency department of a hospital''; and

(III) by striking ''paragraph (2)(B)'' and inserting ''paragraph (2)'';

(ii) in subparagraph (B), by inserting ''or a participating emergency facility, as applicable,'' after ''participating provider''; and

(iii) in subparagraph (C)—

(I) in the matter preceding clause (i), by inserting ''by a nonparticipating provider or a nonparticipating emergency facility'' after ''enrollee'';

(II) by striking clause (i);

(III) by striking ''(ii)(I) such services'' and inserting ''(i) such services'';

(IV) by striking ''where the provider of services does not have a contractual relationship with the plan for the providing of services'';

(V) by striking ''emergency department services received from providers who do have such a contractual relationship with the plan; and'' and inserting ''emergency services received from participating providers and participating emergency facilities with respect to such plan;'';

(VI) by striking ''(II) if such services'' and all that follows through ''were provided in-network'' and inserting the following:

''(ii) the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is not greater than the requirement that would apply if such services were provided by a participating provider or a participating emergency facility;''; and

(VII) by adding at the end the following new clauses:

''(iii) the group health plan or health insurance issuer offering group or individual health insurance coverage pays to such provider or facility, respectively, the amount by which the recognized amount (as defined in paragraph (2)(H)) for such services exceeds the cost-sharing amount for such services (as determined in accordance with clause (ii)); and

''(iv) there shall be counted toward any deductible or out-of-pocket maximums applied under the plan any cost-sharing payments made by the participant, beneficiary, or enrollee with respect to such emergency services so furnished in the same manner as if such cost-sharing payments were with respect to emergency

services furnished by a participating provider and a participating emergency facility.''; and

(B) in paragraph (2)—

(i) in the matter preceding subparagraph (A), by inserting ''and subsection (e)'' after ''this subsection'';

(ii) by redesignating subparagraphs (A) through (C) as subparagraphs (B) through (D), respectively;

(iii) by inserting before subparagraph (B), as redesignated by clause (ii), the following new subparagraph:

''(A) EMERGENCY DEPARTMENT OF A HOSPITAL.—The term 'emergency department of a hospital' includes a hospital outpatient department that provides emergency services.''.

(iv) in subparagraph (C), as redesignated by clause (ii)—

(I) in clause (i)—

(aa) by inserting '', or as would be required under such section if such section applied to an independent freestanding emergency department'' after

''section 1867 of the Social Security Act''; and

(bb) by inserting ''or of the independent freestanding emergency department, as applicable'' after ''of a hospital''; and

(II) in clause (ii)—

(aa) by inserting ''or the independent freestanding emergency department, as applicable'' after ''at the hospital''; and

(bb) by inserting '', or as would be required under such section if such section applied to an independent freestanding emergency department,'' after ''section 1867 of such Act'';

(v) by redesignating subparagraph (D), as redesignated by clause (ii), as subparagraph (I); and

(vi) by inserting after subparagraph (C), as redesignated by clause (ii), the following subparagraphs:

''(D) INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT.—The term 'inde-

pendent freestanding emergency department' means a facility that provides emergency or unscheduled outpatient services to patients whose conditions require immediate care in a setting that is geographically separate and distinct from a hospital and independently licensed.

''(E) MEDIAN CONTRACTED RATE.—

''(i) IN GENERAL.—The term 'median contracted rate' means, with respect to an item or service and a group health plan or health insurance coverage offered by a health insurance issuer, the median of the negotiated rates recognized by the plan or issuer as the total maximum payment (including the cost-sharing amount imposed for such services (as determined in accordance with paragraph (1)(C)(ii) or subsection (e)(1)(A), as applicable) and the amount to be paid by the plan or issuer) for the same or a similar item or service that is provided by a provider in the same or similar specialty and provided in the geographic region in which the item or service is furnished.

''(ii) RULEMAKING.—Not later than July 1, 2020, the Secretary shall through rulemaking determine the methodology the plan or issuer shall use to determine the median contracted rate, the information the plan or issuer shall share with the nonparticipating provider involved when making such a determination, and the geographic regions applied for purposes of this subparagraph.

''(F) NONPARTICIPATING EMERGENCY FACILITY; PARTICIPATING EMERGENCY FACILITY.—

''(i) NONPARTICIPATING EMERGENCY FACILITY.—The term 'nonparticipating emergency facility' means, with respect to an item or service and a group health plan or health insurance coverage offered by a health insurance issuer, an emergency department of a hospital or an independent freestanding emergency department, that does not have a contractual relationship with the plan or coverage for furnishing such item or service.

''(ii) PARTICIPATING EMERGENCY FACILITY.—The term 'participating emergency facility' means, with respect to an item or service and a group health plan or health insurance coverage offered by a health insurance issuer, an emergency department of a hospital or an independent freestanding emergency department, that has a contractual relationship with the plan or coverage for furnishing such item or service.

''(G) NONPARTICIPATING PROVIDERS; PARTICIPATING PROVIDERS.—

''(i) NONPARTICIPATING PROVIDER.—The term 'nonparticipating provider' means, with respect to an item or service and a group health plan or health insurance coverage offered by a health insurance issuer, a physician or other health professional who is licensed by the State involved to furnish such item or service and who does not have a contractual relationship with the plan or coverage for furnishing such item or service.

''(ii) PARTICIPATING PROVIDER.—The term 'participating provider' means, with respect to an item or service and a group health plan or health insurance coverage offered by a health insurance issuer, a physician or other health professional who is licensed by the State involved to furnish such item or service and who has a contractual relationship with the plan or coverage for furnishing such item or service.

''(H) RECOGNIZED AMOUNT.—The term 'recognized amount' means, with respect to an item or service—

''(i) in the case of such item or service furnished in a State that has in effect a State law that provides for a method for determining the amount of payment that is required to be covered by a health plan or health insurance issuer offering group or individual health insurance coverage regulated by such State in the case of a participant, beneficiary, or enrollee covered under such plan or coverage and receiving such item or service from a nonparticipating provider, not more than the amount deter-

mined in accordance with such law plus the cost-sharing amount imposed for such item or service (as determined in accordance with paragraph (1)(C)(ii) or subsection (e)(1)(A), as applicable); or

''(ii) in the case of such item or service furnished in a State that does not have in effect such a law, an amount that is at least the median contracted rate (as defined in subparagraph (E)(i) and determined in accordance with the regulations promulgated pursuant to subparagraph (E)(ii)) for such item or service.''.

(b) NON-EMERGENCY SERVICES PERFORMED BY NONPARTICIPATING PROVIDERS AT CERTAIN PARTICIPATING FACILITIES.—

(1) IN GENERAL.—Section 2719A of the Public Health Service Act (42 U.S.C. 300gg–19a) is amended by adding at the end the following new subsection:

''(e) NON-EMERGENCY SERVICES PERFORMED BY NONPARTICIPATING PROVIDERS AT CERTAIN PARTICIPATING FACILITIES.—

''(1) IN GENERAL.—In the case of items or services (other than emergency services to which

subsection (b) applies) furnished to a participant, beneficiary, or enrollee of a health plan (as defined in paragraph (2)(A)) by a nonparticipating provider (as defined in subsection (b)(2)(G)) during a visit at a participating health care facility (as defined in paragraph (2)(B)), with respect to such plan, the plan—

''(A) shall not impose on such participant, beneficiary, or enrollee a cost-sharing amount (expressed as a copayment amount or coinsurance rate) for such items and services so furnished that is greater than the cost-sharing amount that would apply under such plan had such items or services been furnished by a participating provider;

''(B) shall pay to such provider furnishing such items and services to such participant, beneficiary, or enrollee the amount by which the recognized amount (as defined in subsection (b)(2)(H)) for such services exceeds the cost-sharing amount imposed for such services (as determined in accordance with subparagraph (A)); and

''(C) shall count toward any deductible or out-of-pocket maximums applied under the plan

any cost-sharing payments made by the participant, beneficiary, or enrollee with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider.

''(2) DEFINITIONS.—In this subsection:

''(A) HEALTH PLAN.—The term 'health plan' means a group health plan and health insurance coverage offered by a heath insurance issuer in the group or individual market.

''(B) PARTICIPATING HEALTH CARE FACILITY.—

''(i) IN GENERAL.—The term 'participating health care facility' means, with respect to an item or service and a group health plan or health insurance coverage offered by a health insurance issuer, a health care facility described in clause (ii) that has a contractual relationship with the plan or coverage for furnishing such item or service.

''(ii) HEALTH CARE FACILITY DESCRIBED.—A health care facility described in this clause is each of the following:

"(I) A hospital (as defined in 1861(e) of the Social Security Act).

"(II) A critical access hospital (as defined in section 1861(mm) of such Act).

"(III) An ambulatory surgical center (as defined in section 1833(i)(1)(A) of such Act).

"(IV) A laboratory.

"(V) A radiology or imaging center.".

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to plan years beginning on or after January 1, 2021.

(c) PREVENTING CERTAIN CASES OF BALANCE BILLING.—Section 1128A of the Social Security Act (42 U.S.C. 1320a–7a) is amended by adding at the end the following new subsections:

"(t)(1) In the case of an individual with benefits under a health plan or health insurance coverage offered in the group or individual market who is furnished on or after January 1, 2021, emergency services with respect to an emergency medical condition during a visit at an emergency department of a hospital or an independent

freestanding emergency department (as defined in section 2719A(b)(2) of the Public Health Service Act)—

''(A) if the emergency department of a hospital or independent freestanding emergency department holds the individual liable for a payment amount for such emergency services so furnished that is more than the cost-sharing amount for such services (as determined in accordance with section 2719A(b)(1)(C)(ii) of the Public Health Service Act); or

''(B) if any health care provider holds such individual liable for a payment amount for an emergency service furnished to such individual by such provider with respect to such emergency medical condition and visit for which the individual receives emergency services at the hospital or emergency department that is more than the cost-sharing amount for such services furnished by the provider (as determined in accordance with section 2719A(b)(1)(C)(ii) of the Public Health Service Act);

the hospital, emergency department, independent freestanding emergency department, or health care provider, respectively, shall be subject, in addition to any other penalties that may be prescribed by law,

to a civil money penalty of not more than $[____] for each specified claim.

''(2) The provisions of subsections (c), (d), (e), (g), (h), (k), and (l) shall apply to a civil money penalty or assessment under paragraph (1) or subsection (u) in the same manner as such provisions apply to a penalty, assessment, or proceeding under subsection (a).

''(3) In this subsection and subsection (u):

''(A) The terms 'emergency medical condition' and 'emergency services' have the meanings given such terms, respectively, in section 2719A(b)(2) of the Public Health Service Act.

''(B) The terms 'group health plan', 'health insurance issuer', and 'health insurance coverage' have the meanings given such terms, respectively, in section 2791 of the Public Health Service Act.

''(u)(1) Subject to paragraph (2), in the case of an individual with benefits under a health plan or health insurance coverage offered in the group or individual market who is furnished on or after January 1, 2021, items or services (other than emergency services to which subsection (t) applies) at a participating health care facility by a nonparticipating provider, if such provider holds such individual liable for a payment amount for such an item or service furnished by such provider during a visit at such

facility that is more than the cost-sharing amount for such item or service (as determined in accordance with section 2719A(e)(1)(A) of the Public Health Service Act), such provider shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $[____] for each specified claim.

''(2) Paragraph (1) shall not apply to a nonparticipating provider (other than a facility-based provider), with respect to items or services furnished by the provider at a participating health care facility to a participant, beneficiary, or enrollee of a health plan or health insurance coverage offered by a health insurance issuer, if the provider is in compliance with the requirement of paragraph (3). For purposes of the previous sentence, the term 'facility-based provider' means emergency medicine providers, anesthesiologists, pathologists, radiologists, neonatologists, assistant surgeons, hospitalists, intensivists, or other providers as determined by the Secretary.

''(3) (A) For purposes of paragraph (2) a nonparticipating provider is in compliance with this paragraph, with respect to items or services furnished by the provider at a participating health care facility to a participant, beneficiary, or enrollee of a health plan or health insurance

coverage offered by a health insurance issuer, if the provider—

''(i)(I) provides to the participant, beneficiary, or enrollee (or to a representative of the participant, beneficiary, or enrollee), on the date on which the participant, beneficiary, or enrollee makes an appointment to be furnished such items or services, if applicable, and on the date on which the individual is furnished such items and services—

''(aa) an oral explanation of the written notice described in item (bb) and such documentation of the provision of such explanation, as the Secretary determines appropriate; and

''(bb) a written notice specified, not later than July 1, 2020, by the Secretary through rulemaking that—

''(AA) contains the information required under subparagraph (B); and

''(BB) is signed and dated by the participant, beneficiary, or enrollee; and

''(II) retain, for a period specified through rulemaking by the Secretary, a copy of the documenta-

tion described in subclause (I)(aa) and the written notice described in subclause (I)(bb); and

''(ii) obtains from the participant, beneficiary, or enrollee (or representative) the consent described in subparagraph (C).

''(B) For purposes of subparagraph (A)(i), the information described in this subparagraph, with respect to a nonparticipating provider and a participant, beneficiary, or enrollee of a health plan or health insurance coverage offered by a health insurance issuer, is a notification of each of the following:

''(i) That the health care provider is a nonparticipating provider with respect to the group health plan or health insurance coverage.

''(ii) The estimated amount that such provider will charge the participant, beneficiary, or enrollee for such items and services involved.

''(C) For purposes of subparagraph (A)(ii), the consent described in this subparagraph, with respect to a participant, beneficiary, or enrollee of a group health plan or health insurance coverage offered by a health insurance issuer, who is to be furnished items or services by a nonparticipating provider, is a document specified by the Secretary through rulemaking that—

''(i) is signed by the participant, beneficiary, or enrollee (or by a representative of the participant, beneficiary, or enrollee) not less than 24 hours prior to the participant, beneficiary, or enrollee being furnished such items or services by such provider;

''(ii) acknowledges that the participant, beneficiary, or enrollee has been—

''(I) provided with a written estimate and an oral explanation of the charge that the participant, beneficiary, or enrollee will be assessed for the items or services anticipated to be furnished to the participant, beneficiary, or enrollee by such nonparticipating provider; and

''(II) informed that the payment of such charge by the participant, beneficiary, or enrollee will not accrue toward meeting any limitation that the group health plan or health insurance coverage places on cost-sharing; and

''(iii) documents the consent of the participant, beneficiary, or enrollee to—

''(I) be furnished with such items or services by such nonparticipating provider; and

''(II) in the case that the individual is so furnished such items or services, be charged an amount that may be greater than the amount

that would otherwise be changed the individual if furnished by a participating provider with respect to such items or services and plan or coverage.

''(4) For purposes of this subsection, the terms 'nonparticipating provider' and 'participating health care facility' have such meanings given such terms under subsections (b)(2) and (e)(2), respectively, of section 2719A of the Public Health Service Act.''.

(d) STATE ALL PAYER CLAIMS DATABASES.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall make one-time grants to eligible States for the purposes described in paragraph (2).

(2) USES.—A State may use a grant received under paragraph (1) for one of the following purposes:

(A) To establish an All Payer Claims Database for the State.

(B) To maintain an existing All Payer Claims Databases for the State.

(3) ELIGIBILITY.—To be eligible to receive a grant under paragraph (1) a State shall submit to the Secretary an application at such time, in such manner, and containing such information as the Sec-

retary specifies. Such information shall include, with respect to an All Payer Claims Database for the State, at least specifics on how the State will ensure uniform data collection through the database and the security of such data submitted to and maintained in the database.

(4) ALL PAYER CLAIMS DATABASE.—For purposes of this subsection, the term ''All Payer Claims Database'' means, with respect to a State, a State database that may include medical claims, pharmacy claims, dental claims, and eligibility and provider files, which are collected from private and public payers.

(5) AUTHORIZATION OF APPROPRIATIONS.—To carry out this subsection, there are appropriated $50,000,000, to remain available until expended.