

## Open Season in Sacramento

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It's open season again in Sacramento: The legislative session is in full swing and an avalanche of over 3,000 bills has been introduced (so far). The political landscape is rocky: The legislature is faced with serious revenue shortfalls and a hotly contested budget that relies on speculative funds, while unemployment has surpassed 10% and is expected to climb further. Making matters worse, Republicans and Democrats are poised for political stalemates as major concessions during the budget negotiations have led many to dig in their heels.

After sorting through a mountain of legislation, I have selected several bills that have the potential to significantly impact our patients and our practice. Of course, this is by no means an exhaustive examination, and bills addressing comprehensive reform have largely been left for another forum.

### **SB 316 (Alquist): 85% Medical Loss Ratio**

This bill would require health service plans/insurance companies to dedicate at least 85% of their total plan revenue (premiums, co-pays, etc.) on "health care benefits." "Health care benefits" does not include administrative costs, profits, dividends, stock options, commissions, administrative fines, etc.

Currently, health plans and insurers charge market-based premiums that are driven, at least in part, by management whose central role is to satisfy the fiduciary duty to shareholders of profit maximization. This duty leads to conflicting, and often perverse, outcomes when providing quality health insurance to enrollees. Currently, a health plan fiduciary must focus on creating the lowest medical loss ratio possible (MLR = cost to provide coverage services/ total revenue). This motive pressures company fiduciaries to cover only the healthiest patients, eliminate covered services, reduce payments to providers, and raise premiums.

Under this bill, a health plan would increase its profits primarily by increasing market share, thereby placing downward pressure on premiums, encouraging expansion of covered services, and reducing the motive to shortchange providers. Although sure to confront fierce battles by insurance companies, this legislation has the potential to revolutionize healthcare in California.

### **AB 911 (Lieu): Emergency Department Overcrowding**

Sponsored by Cal/ACEP, this bill strives to address the dangerously overcrowded conditions in California's emergency departments (EDs). AB 911 would require hospitals to regularly assess the level of crowding in the ED, based on a NEDOCS

(National Emergency Department Overcrowding Scale) score and develop a plan for how to best utilize hospital space and personnel at each level of crowding on the index. Although this bill does not require the use of hallway beds in the inpatient units, it does allow individual hospitals to devise plans including this option as necessary. This will also improve surge capacity and allows hospitals to better respond to external disasters.

### **AB 542 (Feuer): Adverse "Never" Events**

This bill requires the state to develop and implement policies on non-payment of healthcare providers in the Healthy Families and Medi-Cal programs for hospital-acquired conditions and adverse events. This bill is concerning in its deceiving simplicity. As payers are seeking to measure "quality" in medical care, there is a concern that payment for medical errors should not occur.

The danger of this bill is multifaceted. Not only is the list of "never" events overly expansive (catheter-associated infections including UTI, line sepsis, mediastinitis post CABG; maternal death or disability associated with pregnancy within two days post-partum, etc.), there is no mechanism for payment of those physicians and hospitals who seek to ameliorate these adverse events. Instead of funneling care directly to those who have experienced an unfortunate complication, this bill turns these patients into "hot potatoes."

Further, those patients who are more likely to experience an adverse medical outcome could experience massive barriers to accessing medical care because physicians would presumably shy away from attempting all but the simplest cases. This has the potential to place further pressure on call panels as it will become increasingly important for specialists to have the ability to select their patients, and it would increase overcrowding as finding appropriate care becomes increasingly difficult.

### **AB 1126 (Hernandez): Fair Payment for Public Employees' Retirement System (PERS) PPO Patients**

This bill would prohibit providers of emergency services from billing PERS PPO patients for the amount that their insurer arbitrarily underpaid. There is no fair payment mechanism. This represents a potential expansion of the *Prospect* decision from the sphere of HMO, Knox-Keene regulated plans to PPO plans. Without a mechanism for fair payment, EMTALA-mandated providers are at the mercy of insurance companies who can pay any arbitrary amount of their choosing.