California Health Care Legislation and Litigation in 2013: Another Year of Major Reform

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The year 2013 was another year of significant change in California health law, as the Affordable Care Act (ACA) continued to prompt health care reform at many levels. For example, during a special session, the Legislature extended Medi-Cal coverage to more than one million new beneficiaries, and also spurred private coverage by both Knox-Keene Act plans and insurance plans toward conformity with many ACA standards. During its regular session, the Legislature made it easier for this vast number of newly insured individuals to find providers by expanding the scope of practice rights of non-physician providers, such as physical therapists, pharmacists, midwives, and nurse practitioners.

There also were a number of significant appellate decisions, which are especially notable given the Legislature's expansion of health care coverage. These include, for example, a California Supreme Court decision that broadened the scope of non-physician practice by holding that unlicensed school personnel can administer insulin if a nurse is not available. Also notable, given the expansion of Medi-Cal coverage, was a Ninth Circuit Court of Appeals decision that rejected a Supremacy Clause challenge to the California Department of Health Care Services' reduction of Medi-Cal provider payment rates.

This article discusses these and other significant health care-related legislation and appellate court decisions arising in 2013.

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Affordable Care Act Implementation Bills

In January 2013, Governor Brown called a special session of the Legislature to address issues relating to California's implementation of the ACA. During the special session, the Legislature enacted five bills, which expanded the Medi-Cal program, gave definition to the Medi-Cal/Exchange Bridge Program, and reformed coverage rules for California health care service plans and insurers to ensure conformity with key ACA standards.

Medi-Cal Expansion

The Medi-Cal bills—Assembly Bill (AB) 1 X1 and Senate Bill (SB) 1 X1—expanded Medi-Cal eligibility and coverage, effective January 1, 2014. According to the "Findings" section in SB 1 X1, this expansion is expected to result in 1.2 to 1.6 million new enrollees.[1] The groups affected by the expansion include:

- *Low-income adults:* Medi-Cal eligibility was extended to citizens and qualified immigrants under age 65, who are not pregnant or otherwise currently eligible for Medi-Cal coverage, and who have incomes up to 138% of the federal poverty level ("FPL").[2] These new beneficiaries must be enrolled in a managed care program.[3]
- *Pregnant women*: Coverage for women during a pregnancy and to the end of the month in which the sixtieth day

thereafter occurs, and for children under age two, was expanded to include full-scope Medi-Cal benefits.[4]

- *Foster children*: Eligibility for Medi-Cal also was extended to individuals who are in foster care on their 18th birthday, with such eligibility to continue until their 26th birthday.[5]

In 2010, California created a Low Income Health Program (LIHP) to provide coverage to uninsured, childless adults ages 19 to 64, and to parents and caretaker relatives, with incomes up to 200% of the FPL. Under AB 1 X1, individuals who were enrolled in this program as of December 31, 2013 and who had incomes up to 138% of the FPL were to be automatically transitioned to a Medi-Cal managed care program.[6] According to the California Department of Health Care Services (DHCS), which administers the Medi-Cal program, on December 31, 2013, approximately 630,000 such LIHP enrollees were automatically transitioned to Medi-Cal, giving California a significant head start on achieving its Medi-Cal enrollment goals.[7]

AB 1 XI and SB 1 XI also eased the Medi-Cal income and resource eligibility requirements. For example, these bills adopted the Modified Adjusted Gross Income system (MAGI) for determining Medi-Cal benefits for certain groups. Under MAGI, an applicant's assets as well as the first 5% of his or her income are generally disregarded in determining eligibility.[8] In addition, instead of reviewing income and resources twice a year, the law now provides that eligibility will be determined annually.[9] Documentation requirements were also loosened. DHCS is now required to accept the attestation of the individual applicant or beneficiary as to eligibility requirements, such as the applicant's age, date of birth, household income, state residency, or pregnancy.[10] While DHCS is tasked with verifying this information, it is now required to look first to government databases before contacting the applicant or beneficiary and must take steps to minimize eligibility contacts with that individual. Beneficiaries are permitted to respond to requests for information via the Internet, mail or telephone, and in person.[11]

Of importance to hospitals, Medi-Cal is now able to provide benefits during a "presumptive eligibility period" to individuals who have been determined to be eligible on the basis of preliminary information provided by a "qualifying hospital." A hospital qualifies to make these determinations if it is a participating Medi-Cal provider, notifies DHCS that it intends to make such determinations, and follows applicable rules.[12]

Bridge Plan

The Bridge Plan Bill—SB 3 X1—provides rules for new products called "Bridge Plan" health insurance products, which are designed to prevent "churning"—repeated exit and entry into Medi-Cal and Exchange Program coverage as a beneficiary's income fluctuates above and below Medi-Cal eligibility levels.[13] Under the bill, to offer a qualified Bridge Plan product, a health care service plan or insurer must both: (i) have a contract with DHCS to provide managed care services; and (ii) meet the requirements to contract with the Exchange as a qualified health plan.[14]

Enrollment in a Bridge Plan product is limited to persons who have lost their Medi-Cal eligibility and whose incomes do not exceed 250% of the FPL, a parent or caretaker relative of a child enrolled in Medi-Cal, and certain other individuals. Individuals or families may only enroll in Bridge Plans to maintain the continuity of the plan in which they or their family members are already enrolled. The price of a Bridge Plan must be lower than or equal to the price of the MCO's (Medicaid managed care organization) lowest cost Silver Plan. Bridge Plans may limit enrollment of persons in their target populations only if they have insufficient provider capacity.[15]

Enforcing Private Plan Conformity with the ACA

The health coverage bills—SB 2 X1 (for HMOs) and AB 2 X1 (for PPOs)—revise California individual and small group coverage laws to require Knox-Keene Act plans and health insurers (hereafter Carriers) to sell plans that conform to many ACA provisions.[16] These bills require:

- *Affirmative marketing*: Carriers must "affirmatively" market and sell all of their plans in each of their service areas.[17]
- *Guaranteed issue and renewal*: Carriers are prohibited from imposing preexisting condition limitations for any individual non-grandfathered health plan or insurance coverage issued, amended, or renewed after January 1, 2014.[18] In addition, Carriers may not establish rules for eligibility in an individual plan based on health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or any other health status-related factor.[19]
- *Open enrollment periods*: For plan years beginning in 2014, Carriers must provide an open enrollment period from October 1, 2013 to March 21, 2014. For plan years beginning after January 1, 2015, plans must provide an open enrollment period from October 15 to December 7 of the preceding calendar year. Enrollment also is permitted as the result of certain triggering events, such as the loss of other coverage or a permanent move.[20]
- *Single statewide risk pool*: Carriers must consider the claims experience of all enrollees in individual non-grandfathered

plans in the State as a single risk pool. Premiums between plans (product types) may vary based on limited factors, such as the actuarial and cost-sharing design, provider network, delivery system and utilization management practices, benefits provided beyond essential health benefits (EHBs), administrative costs, etc.[21] Rates within a particular plan type may vary based only on specific factors—age, geographic region and family size.[22]

Both bills include similar provisions for small group plans.

Bills Expanding the Scope of Practice by Non-Physicians

Notable among the bills passed during the regular legislative session were several that expand the scope of unsupervised and independent practice by non-physician healthcare practitioners, such as physical therapists, pharmacists, midwives, and nurse practitioners.

Physical Therapists

AB 1000 amends the Physical Therapy Practice Act[23] to allow patients direct access to physical therapist services[24] without first obtaining a physician or podiatrist referral.[25] Such treatment, however, must be within the scope of the physical therapist's practice and is limited to forty-five calendar days or twelve visits, whichever occurs first.[26] After that, the patient must be seen by a physician who must sign the plan of care.[27] Before providing any treatment, the physical therapist must provide oral and written notice to the patient as specified in California Business & Professions Code (B & P Code) section 2620.1(e).[28] Additionally, if at any time the physical therapist has a reason to believe that the patient (a) has signs or symptoms of a condition that requires treatment beyond the scope of the therapist's practice or (b) is not progressing towards the therapist's documented treatment goals, the therapist must refer the patient to a physician or person licensed to practice dentistry, podiatric medicine, or chiropractic medicine, as appropriate. With the patient's authorization, the physical therapist also must notify the patient's physician, if any, that he or she is treating the patient.[29]

Licensed Midwives

AB 1308 amends the Licensed Midwifery Practices Act of 1993[30] to authorize a licensed midwife to attend cases of normal pregnancy and childbirth, and to provide prenatal, intra-partum, and postpartum care (including family-planning care), without physician supervision.[31] Normal pregnancy and childbirth is now specifically defined in B & P Code section 2508 as, among other things: (1) the absence of any preexisting maternal disease or condition likely to affect the pregnancy; (2) the absence of any significant disease arising from the pregnancy; (3) a singleton fetus; and (4) a cephalic presentation.[32] If at any time the client's condition deviates from normal, the licensed midwife is required to immediately refer or transfer the client to a physician.[33] The new legislation also authorizes a licensed midwife to directly obtain supplies, order testing, and receive reports that are necessary to the practice of midwifery and are consistent with the midwife's scope of practice.[34] The new law requires that the midwife advise each prospective client verbally and in writing of the specific arrangement for referring the client to a physician in the event of a complication.[35] The written disclosure must be signed by the client and the licensed midwife and kept in the client's medical record.[36]

Nurse Practitioners, Nurse-Midwives and Physician Assistants

AB 154 amends existing law, including the Nursing Practice Act[37] and Physician Assistant Practice Act[38] to authorize a nurse practitioner, certified nurse-midwife, or physician assistant who has completed a statutorily-specified training program and achieved clinical competency to perform abortions by medication or aspiration techniques in the first trimester of a pregnancy.[39] The requirements of the training program are specified in B & P Code sections 2725.4 and 3502.4.

Pharmacists

SB 493 expands the scope of practice by pharmacists by authorizing pharmacists to, without a prescription, furnish self-administered hormonal contraceptives, nicotine replacement products, and prescription medications not requiring a diagnosis that are recommended by the Centers for Disease Control for international travelers.[40] Additionally, pharmacists, in coordination with a prescriber, are authorized to order and interpret tests for the efficacy and toxicity of drug therapies, and to initiate and administer routine vaccinations.[41] This bill also added B & P Code section 4016.5, which provides for Pharmacy Board recognition of a new category of "advanced practice pharmacists"[42] who may perform patient assessment, order and interpret drug therapy-related tests, refer patients to other providers, and participate in the evaluation and management of diseases.[43]

California Supreme Court Decisions

Important California appellate decisions include the following California Supreme Court cases:

***Am. Nurses Ass'n v. Torlakson,* 57 Cal. 4th 570 (2013).**

The parents of four diabetic students in California public schools filed a class action lawsuit in federal court alleging that certain California schools violated federal law by refusing to

allow unlicensed school personnel to administer insulin when no nurse was available, which required the parents to go to the school to administer the insulin themselves. A settlement agreement required the California Department of Education to issue an opinion, which provided that a "voluntary school employee who is unlicensed but who has been adequately trained to administer insulin pursuant to the student's treating physician's orders" is authorized to administer insulin.[44] After the Nurses Association of America filed suit, the Superior Court invalidated the opinion, ruling that state law did not authorize unlicensed school personnel to administer insulin. The court of appeal affirmed that judgment.

The California Supreme Court reversed, holding that Education Code section 49423 and its implementing regulations allow "trained, unlicensed school personnel to administer prescription medications, including insulin, in accordance with written statements of individual students' treating physicians, with parental consent . . . and that persons who act under this authority do not violate the [Nursing Practice Act]."[45]

***El-Attar v. Hollywood Presbyterian Med. Ctr.,* 56 Cal. 4th 976 (2013).**

A physician, Dr. El-Attar, challenged the decision of a hospital governing board to deny his application for reappointment to the medical staff. The board's decision was affirmed by the hospital's judicial review committee ("JRC") following two years of peer review proceedings. The JRC's decision was affirmed by an administrative appeals board and the hospital's governing board. The superior court then denied Dr. El-Attar's petition for writ of administrative mandamus. The court of appeal reversed the superior court's judgment, however, holding that it was a per se violation of Dr. El-Attar's fair procedure rights for the hospital medical staff's medical executive committee (MEC) to delegate to an ad hoc committee of the governing board the responsibility of appointing the hearing officer and physician members of the JRC for peer review proceedings regarding a decision of the governing board. The hospital bylaws required those appointments to be made by the MEC.

The California Supreme Court reversed the court of appeal, holding that, even though the appointment procedure violated the hospital's bylaws, "the violation was not material and, by itself, did not deprive Dr. El-Attar of a fair hearing."[46] The Court applied the principle that "departures from an organization's procedural rules will be disregarded unless they produced some injustice."[47] The Court also explained that, because "the hospital itself is ultimately responsible for the health and safety of the patients," the governing body may at times "assume the role normally played by the medical staff in the peer review process without necessarily violating basic norms of fair procedure."[48] Indeed, "although the governing board must give deference to the determinations of the medical staff, it may take unilateral action if warranted."[49]

***City of Riverside v. Inland Empire Patients Health and Wellness Ctr., Inc.,* 56 Cal. 4th 729 (2013).**

The City of Riverside filed a nuisance suit against the owners and operators of a medical marijuana distribution facility. The trial court granted the city a preliminary injunction, which prohibited defendants from using the facility to distribute marijuana, on the ground that cities may abate as nuisances uses of land that violate their zoning and licensing regulations. It also concluded that neither California's Compassionate Use Act ("CUA") nor its Medical Marijuana Program ("MMP") preempted the City's zoning and licensing regulation of medical marijuana distribution or production facilities. The court of appeal affirmed, finding that state law did not preempt the City's zoning prohibition of such facilities.

The California Supreme Court affirmed, holding that neither the CUA nor the MMP "expressly or impliedly preempts the authority of California cities and counties, under their traditional land use and police powers, to allow, restrict, limit, or entirely exclude facilities that distribute medical marijuana, and to enforce such policies by nuisance actions."[50] The Court explained that "the CUA and MMP are careful and limited forays into the subject of medical marijuana, aimed at striking a delicate balance in an area that remains controversial, and involves sensitivity in federal-state relations."[51]

***Beeman v. Anthem Prescription Mgmt., LLC,* 58 Cal. 4th 329 (2013).**

Owners of independent pharmacies filed a federal class action lawsuit against certain pharmacy benefits managers to compel compliance with Civil Code section 2527, which requires prescription drug claims processors to compile and summarize factual information on pharmacy fees and transmit that information to their clients (i.e., third-party payors, such as health insurance companies). The defendants asserted that enforcement of section 2527 violated their First Amendment rights. The Ninth Circuit certified to the California Supreme Court the issue whether the free speech clause of the California Constitution prohibits enforcement of section 2527.

The California Supreme Court held that: (1) Civil Code section 2527 does implicate the right to free speech guaranteed by article I of the California Constitution, which protects the right to both speak and to withhold speech on all subjects—including factual information regarding commercial transactions;[52] (2) the rational basis test applies to determine whether section 2527 infringes the free speech clause because the statute compels commercial speakers to privately transmit purely factual information related to their business affairs containing no message with which the speaker disagrees;[53] and (3) section 2527 is rationally related to the legitimate purpose of promoting informed decision-making about prescription drug reimbursement rates.[54]

Ninth Circuit Decisions

The Ninth Circuit Court of Appeals published the following significant decisions addressing California health law issues:

***Managed Pharmacy Care v. Sebelius,* 716 F.3d 1235 (9th Cir. 2013).**

The Ninth Circuit reversed district court decisions in four cases and vacated preliminary injunctions prohibiting the California Department of Health Care Services (DHCS) from implementing Medi-Cal provider reimbursement rate reductions authorized by the California legislature. These cases included *Douglas v. Independent Living Centers of Southern California, Inc.*,[55] which was remanded to the Ninth Circuit by the Supreme Court after U.S. Health and Human Services Secretary Kathleen Sebelius approved California's request to reduce Medi-Cal rates. Asserting claims against the Secretary under the Administrative Procedure Act (APA) and against the Director of DHCS under the Supremacy Clause, Medi-Cal providers and beneficiaries claimed that the reimbursement rate reductions did not comply with 42 U.S.C. section 1396a(a)(30)(A) (§ 30(A)). The plaintiffs relied on *Orthopaedic Hospital v. Belshe*, 103 F.3d 1491 (9th Cir. 1997), which interpreted § 30(A) as requiring a state seeking to reduce Medicaid reimbursement rates first to consider the costs of providing medical services subject to the rate reductions.

The Ninth Circuit held that *Orthopaedic* was not controlling because it did not consider the Secretary's interpretation of § 30(A) and her approval of the rates.[56] Agreeing with the D.C. Circuit, the Ninth Circuit held that the Secretary's approval of California's requested reimbursement rates—including her permissible view that, prior to reducing rates, states need not follow any specific procedural steps, such as considering providers' costs—is entitled to deference under *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*,[57] and ruled that the Secretary's approval complied with the APA.[58] Leaving open the issue of a Medicaid provider's private right of action, the Ninth Circuit further held that the plaintiffs were unlikely to succeed on the merits of their Supremacy Clause claims against DHCS because, even assuming that the Supremacy Clause provides a private right of action, the Secretary reasonably determined that the State's reimbursement rates complied with section 30(A).[59] Finally, the Ninth Circuit held that none of the plaintiffs had a viable takings claim because Medicaid, as a voluntary program, does not create property rights.[60] On January 13, 2014, the U.S. Supreme Court denied a petition for writ of certiorari, making the Ninth Circuit's decision final.

The Ninth Circuit's decision may allow California to move forward with Medi-Cal provider rate reductions, including those enacted in the 2011-2012 budget (i.e., AB 97). It is unclear if DHCS will seek to implement any of the provider rate reductions retroactively to the effective date of the legislation; however, the current year budget assumes retroactive implementation.

***Pickup v. Brown,* 728 F.3d 1042 (9th Cir. 2013).**

Plaintiffs challenged a California statute banning state-licensed mental health professionals from engaging in therapy aimed at changing the sexual orientation of minors on First Amendment grounds. The Ninth Circuit upheld the statute under rational basis review, holding that it did not infringe on the constitutional rights of parents or licensed health care providers.[61]

***Cal. Ass'n of Rural Health Clinics v. Douglas,* 738 F.3d 1007 (9th Cir. 2013).**

California Welfare Institutions Code section 14131.10, which eliminated certain Medi-Cal benefits such as podiatry, optometry, adult dentistry, and chiropractic services, was held invalid because the limitations adopted by California are prohibited by the Medicaid Act, 42 U.S.C. § 1396 *et seq*.[62]

Conclusion

Last year was an important year for health care legislation in California as the State continued to enact health care coverage reforms. In addition, the Supreme Court and the Ninth Circuit issued a number of decisions with far-reaching implications. These legislative reforms and cases have already impacted the entire health care system and the way in which health care is provided in California. ■

Endnotes

1 2013 Cal. Stat., 1st Ex.Sess., c. 4, p. 4 (SB 1 X1 Section 1(e)(2)).

2 Cal. Welf. & Inst. Code § 14005.60.

3 *Id.* at § 14103.

4 Cal. Ins. Code § 12698.30.

5 Cal. Welf. & Inst. Code §14005.28.

6 2013 Cal. Stat., 1st Ex.Sess., c. 1, p. 15 (AB 1 X1, section 10), codified at Cal. Welf. & Inst. Code § 14005.61.

7 News Release, No. 13-07, Cal DHCS, California's Low Income Health Program Transitions Hundreds of Thousands of New Members to Medi-Cal (Dec. 31, 2013) *available at* http://www.dhcs.ca.gov/formsandpubs/publications/opa/Documents/2013/13-07%20LIHP%20Medi-Cal%20Expansion%2012-31-13%20Final%20Version.pdf.

8 *See* 42 U.S.C. § 1396a(e)(14)(C); Cal. Welf. & Inst. Code §§ 14005.30 & 14005.64.

9 Cal. Welf. & Inst. Code § 14005.37.

10 *Id.* at § 15926(f)(2).

11 *Id.* at §§ 14013.3 & 14005.65.

12 *Id.* at § 14011.66.

13 2013 Cal. Stat., 1st Ex.Sess., c. 3. (SB 3 X1).

14 Cal. Govt. Code at § 100504.5.

15 Cal. Welf. & Inst. Code § 14005.70.

16 2013 Cal. Stat., 1st Ex.Sess., c. 1. (AB 2 X1); 2013 Cal. Stat., 1st Ex.Sess., c. 2. (SB 2 X1).

17 Cal. Health & Safety Code § 1399.845; Cal. Ins. Code § 10965.3.

18 Cal. Health & Safety Code §1357.51(b)(1); Cal. Ins. Code § 10965.3(b).

19 Cal. Health & Safety Code § 1388.849(g); Cal. Ins. Code § 10965.3(g).

20 Cal. Health & Safety Code §§ 1399.849(c) & (d); Cal. Ins. Code §§ 10965.3(c) & (d).

21 Cal. Health & Safety Code § 1399.849(h)(3); Cal. Ins. Code § 10965.3(h).

22 Cal. Health & Safety Code § 1399.855; Cal. Ins. Code § 10965.9.

23 The Act is codified in Business & Professions Code section 2600 *et seq.*

24 The bill also expands The Moscone-Knox Professional Corporation Act as to the professionals that a medical or podiatry corporation may include as shareholders and employees rendering professional services. Cal. Bus. & Prof. Code § 2406; Cal. Corp. Code § 13401.5. Discussion of these amendments is beyond the scope of this article.

25 Cal. Bus. & Prof. Code § 2620.1.

26 Cal. Bus. & Prof. Code § 2620.1(a)(4). This restriction does not extend to a physical therapist providing only wellness physical therapy services. *Id.* at § 2620.1(c).

27 Cal. Bus. & Prof. Code § 26201.1(a)(4).

28 Cal. Bus. & Prof. Code § 2620.1 (e).

29 Cal. Bus. & Prof. Code § 2620.1(a)(1) & (3). The physical therapist must also satisfy the financial interest disclosures and other requirements. Cal. Bus. & Prof. Code § 2620.1(a)(2).

30 Cal. Bus. & Prof. Code §§ 2505–2521.

31 Cal. Bus. & Prof. Code § 2507.

32 Cal. Bus. & Prof. Code § 2507(b)(1).

33 Cal. Bus. & Prof. Code § 2507(c).

34 Cal. Bus. & Prof. Code § 2507(f).

35 Cal. Bus. & Prof. Code § 2508.

36 *Id.*

37 Cal. Bus. & Prof. Code § 2700 *et seq.*

38 Cal. Bus. & Prof. Code § 3500 *et seq.*

39 Cal. Bus. & Prof. Code § 2253.

40 Cal. Bus. & Prof. Code §§ 4052(a), 4052.3(a) & 4052.9(a).

41 Cal. Bus. & Prof. Code § 4052(a)(12).

42 *See* Cal. Bus. & Prof. Code § 4210 for qualifications.

43 Cal. Bus. & Prof. Code § 4016.5.

44 *Am. Nurses Ass'n v. Torlakson*, 57 Cal.4th 570, 578 (2013).

45 *Id.* at 591.

46 *El-Attar v. Hollywood Presbyterian Med. Ctr.*, 56 Cal. 4th 976, 983 (2013).

47 *Id.* at 990.

48 *Id.* at 993.

49 *Id.*

50 *City of Riverside v. Inland Empire Patients Health and Wellness Ctr., Inc.*, 56 Cal.4th 729, 762 (2013).

51 *Id.*

52 *Beeman,* 58 Cal. 4th at 363-64.

53 *Id.*

54 *Id.* at 24.

55 132 S.Ct. 1204 (2012).

56 *Managed Pharmacy Care v. Sebelius*, 716 F.3d 1235, 1245-46 (9th Cir. 2013).

57 467 U.S. 837 (1984).

58 *Id.* at 1247-49.

59 *Id.* at 1251-52.

60 *Id.* at 1252.

61 *Pickup v. Brown*, 728 F.3d 1042, 1057-58, 1060-61 (9th Cir. 2013).

62 *Cal. Ass'n of Rural Health Clinics*, 738 F.3d at 1016-17.