Date of Hearing: May 18, 2020

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
AB 2830 Wood – As Amended May 12, 2020

SUBJECT: Health Care Payments Data Program.

SUMMARY: Renames the Health Care Cost Transparency Database to the Health Care Payments Data System (system). Requires the Office of Statewide Health Planning and Development (OSHPD) to establish, implement, and administer the Health Care Payments Data Program (HPD Program) to administer the system and collect data on all California residents to the extent feasible and permissible under state and federal law. Requires OSHPD to convene a HPD Program advisory committee (advisory committee) to assist and advise the OSHPD Director in formulating HPD Program policies regarding data collection, management, use, and access, and development of public information to meet the goals of the HPD Program. Requires OSHPD to develop guidance to require data submission from the entities specified in this bill. Specifies the mandatory and voluntary submitters for purposes of the HPD Program. Specifies privacy and confidentiality requirements. Specifically, **this bill**:

Legislative Intent

1) Makes various finding and declarations on the importance of transparency to achieve a sustainable health care system with more equitable access to affordable and quality health care for all; and, that California has a substantial public interest in the price, cost, utilization, equity, and quality of health care services.

2) Revises the intent of the Legislature for OSHPD to complete a system by July 1, 2022.

HPD Program

3) Requires OSHPD to establish, implement, and administer the HPD Program to administer the system to collect data on all California residents to the extent feasible and permissible under state and federal law.

Advisory Committee

4) Requires OSHPD to convene an , consisting of no fewer than nine and no more than 11 members who are health care stakeholders and experts, including, but not limited to, all of the following:

    a) Health care service plans (health plans), including specialized health plans;
    b) Insurers that have a certificate of authority from the California Department of Insurance (CDI) Commissioner to provide health insurance, as specified;
    c) Suppliers, as defined in existing law;
    d) Providers, as defined in existing law;
    e) Self-insured employers;
    f) Multiemployer self-insured plans that are responsible for paying for health care services provided to beneficiaries or the trust administrator for a multiemployer self-insured plan;
    g) Businesses that purchase health care coverage for their employees;

h) Organized labor; and,
i) Organizations representing consumers.

5) Requires the Director of OSHPD, the Director of the State Department of Health Care Services (DHCS), and the Executive Director of the California Health Benefit Exchange (exchange), or their officially designated representatives, to be nonvoting ex officio members of the advisory committee.

6) Requires each appointed member to serve a term of two years, except one-half of the initial appointments to be for one year. Requires each appointed member to serve at the discretion of the OSHPD director and may be removed at any time.

7) Requires the chairperson of the advisory committee to be an appointed member and to be elected by a majority of the appointed members.

8) Requires the advisory committee to meet at least quarterly or when requested by the OSHPD Director.

9) Requires the advisory committee to assist and advise the OSHPD Director in formulating HPD Program policies regarding data collection, management, use, and access, and development of public information to meet the goals of the HPD Program. Requires the advisory committee to, through its meetings, provide a forum for stakeholder and public engagement. Authorizes the advisory committee, upon request of the OSHPD Director, to assist and advise on OSHPD's other data programs.

10) Prohibits the advisory committee from having decision making authority related to the administration of the system and to not have a financial interest, individually or through a family member, in the recommendations made to OSHPD.

11) Requires the advisory committee to hold public meetings with stakeholders, solicit input, and set its own meeting agendas; and its meetings to be subject to the Bagley-Keene Open Meeting Act; as specified.

12) Requires members of the advisory committee appointed from outside government to serve without compensation, but to receive a per diem for each day's attendance at an advisory committee meeting. Requires all members to be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the committee.

13) Authorizes OSHPD to convene other committees or workgroups as necessary to support effective operation of the system and these committees may be standing committees or time-limited workgroups, at the discretion of the director.

Data Sets, Contracting, and Hiring Staff

14) Requires OSHPD to ensure that the system can map to other datasets, including public health datasets on morbidity and mortality, and data regarding the social determinants of health.

15) Authorizes OSHPD to contract with a data collection vendor; requires the contracted vendor to have experience in health care databases, including the collection of data for all payer

claims database (APCDs), and experience in the collection of nonclaims based data, such as encounter data.

16) Authorizes OSHPD to enter into exclusive or nonexclusive contracts on a bid or negotiated basis for purposes of implementing this bill, including, but not limited to, hiring staff and consultants, facilitating and conducting meetings, conducting research and analysis, and developing the required reports. Exempts contracts entered into or amended pursuant to this provision to be exempt from the review or approval of the Department of General Services, as specified.

Data Submission

17) Requires OSHPD to develop guidance to require data submission from the entities specified in this bill. Requires the guidance to include a methodology for the collection, validation, refinement, analysis, comparison, review, and improvement of health care data to be submitted by entities, including, but not limited to, data from fee-for-service (FFS), capitated, integrated delivery system, and other alternative, value-based, payment sources, and any other form of payment to health care providers by health plans, health insurers, or other entities described in this bill.

18) Requires mandatory submitters, and authorizes voluntary submitters, to provide health care data, including claim and encounter, member enrollment, provider information, nonclaims-based payments, premiums, and pharmacy rebate data, and provide all of the following to OSHPD:

    a) Utilization data from the health plans' and insurers' medical payments or, in the case of entities that do not use payments data, including, but not limited to, integrated delivery systems, encounter data consistent with the core set of data elements for data submission proposed by the All-Payer Claims Database Council, the University of New Hampshire, and the National Association of Health Data Organizations;

    b) Pricing information for health care items, services, and medical and surgical episodes of care gathered from payments for covered health care items and services, including contracted rates, allowed amounts, fee schedules, and other information regarding the cost of care necessary to determine the amounts paid by health plans, health insurers, and public programs to health care providers and other entities. States that this include nonclaims-based payment information such as deductibles, copayments, and coinsurance and other information as needed to determine the total cost of care.

    c) Personally identifiable information that the plan or insurer possesses, including detailed patient identifiers such as first and last name, address, date of birth, gender or gender identity, and Social Security Number or individual taxpayer identification number, in order to support analyses, including, but not limited to, longitudinal, public health impacts, and social determinants of health analyses. Requires personally identifiable information to be subject to the privacy protections of this bill and prohibits making them publicly available, as specified.

    d) Personal health information, including age, gender, gender identity, race, ethnicity, sexual orientation, health status, health condition, and any other data elements that constitute

personal health information in this bill.

19) Defines "mandatory submitters" to include all of the following:
    a) A health care service plan, including a specialized health care service plan;
    b) An insurer licensed to provide health insurance, as defined in existing law;
    c) A self-insured plan, as specified, or a state entity, city, county, or other political subdivision of the state, or a public joint labor management trust, that offers self-insured or multiemployer-insured plans that pay for or reimburse any part of the cost of health care services;
    d) DHCS, for those enrolled in Medi-Cal and other insurance affordability programs, whether enrolled in Medi-Cal managed care (MCMC), FFS Medi-Cal, or any other payment arrangement;
    e) A provider, as defined, beginning on and after January 1, 2026; and,
    f) A supplier, as defined, beginning on and after January 1, 2026.

20) Defines "voluntary submitters" to include, but not be limited to the following:
    a) A self-insured employer that is not subject to existing law, as specified;
    b) A multiemployer self-insured plan that is responsible for paying for health care services provided to beneficiaries; and,
    c) The trust administrator for a multiemployer self-insured plan.

21) Authorizes OSHPD to establish a form to be used by providers and suppliers, as specified in 19) e) and f) above, for submission of data required by this bill.

22) States that included lines of business for entities subject to this bill, to the extent permitted by state and federal law include all of the following:

    a) Commercial lines of business, including individual, small group, large group, and Medicare Advantage;
    b) Self-insured plans subject to state law, as specified;
    c) Dental, vision, and behavioral health plans;
    d) Medi-Cal plans, to the extent that this information is not provided by DHCS; and,
    e) Student health insurance.

23) Provides that excluded lines of business include all of the following:
    a) Supplemental insurance, including Medicare supplemental coverage;
    b) Stop-loss plans; and,
    c) Chiropractic-only and vision-only plans that do not cover essential health benefits.

24) Requires OSHPD to determine the minimum threshold for mandatory submitters which is not to exceed 50,000 total covered lives for either of the following:
    a) A plan providing comprehensive benefits in commercial, self-insured, or Medicare Advantage products; or,
    b) A plan providing dental-only coverage;

25) Requires a qualified health plan to submit either directly or through the exchange, as determined by the exchange.

26) Requires DHCS to submit information for those enrolled in Medi-Cal and other insurance affordability programs, whether enrolled in MCMC, (FFS) Medi-Cal, or any other payment arrangement.

27) Requires health plans, insurers, and other mandatory submitters to submit monthly all core data, including claims, encounters, eligibility, and provider files;

28) Requires nonclaims payment data files to be submitted, at a minimum, annually.

29) Requires OSHPD to seek data for the three years prior to the effective date of this bill.

30) Requires OSHPD, in ongoing administration of the system, to provide data for no less than three years and may seek data for longer time periods to support the intent of this bill.

31) Requires OSHPD, to the extent possible, to incorporate into the system any data collected from providers, including hospital discharge abstract data records and emergency care data records provided to OSHPD by health facilities and ambulatory surgery data records provided to OSHPD by ambulatory surgical centers.

32) Allows OSHPD to accept and incorporate into the system any available information that will further the goals of the HPD Program.

33) States that OSHPD performs public health activities in implementing this bills and is acting as a health oversight agency, as specified, and that the information collected in this bill is necessary to carry out oversight and projects with public health purposes.

34) States that existing law provisions allowing individuals the right to inquire and be notified when an agency maintains a record on them does not apply to this bill.

35) Requires OSHPD to report the information it receives under this bill in a form that allows valid comparisons across care delivery systems.

36) Requires OSHPD to develop policies and procedures to outline the format and type of data to be submitted under this bill.

37) States that mandatory submitters are responsible for submitting complete and accurate data directly to the system and facilitating data submissions from data owners, including, but not limited to, data feeds from pharmacy benefit managers, behavioral health organizations, and any subsidiaries, affiliates, or subcontractors that a mandatory submitter has contracted with for services covered by this bill.

38) Requires OSHPD or its designee, in the development of the system, to consult with state and federal entities, as necessary, to implement the HPD Program. Requires state entities to assist and provide to OSHPD access to datasets needed to effectuate the intent of this bill.

39) Requires OSHPD to seek data on Medicare enrollees from the federal Centers for Medicare and Medicaid Services and to incorporate that data, to the extent possible.

40) Requires OSHPD to accept data from voluntary submitters if it is provided in a manner and format specified by OSHPD.

41) Requires OSHPD to develop and maintain a master person index, a master provider index, and a master payer index that will enable the matching of California residents longitudinally and across coverage sources, and will enable the matching of providers across practice arrangements, payment sources, and regulators.

42) Requires OSHDP to supplement these indices with data from other public and private sources, including, but not limited to, the following:

    a) Other data maintained by OSHPD;
    b) Vital statistics;
    c) Facility licensure data from the State Department of Public Health;
    d) Health professional licensure data from the Department of Consumer Affairs;
    e) Private sources of valid and reliable data, such as a provider directory utility if it is demonstrably accurate over time.

Data Processes

43) Requires OSHPD to develop data quality and improvement processes and to make these processes publicly available.

44) Requires data quality processes to be applied to each major phase of the system life cycle, including, but not limited to:

    a) Source data intake;
    b) Data conversion and processing;
    c) Data analysis, reporting, and release; and,
    d) Other data processes necessary for the system.

45) Requires OSHPD to provide, upon request of an interested party, to the interested party, and to regularly report to the advisory committee, information on data quality and data quality improvement processes, including, but not limited to, the following:

    a) Descriptions of processes and methodologies;
    b) Periodic updates on known issues and the implications of the issues for data quality and data availability; and,
    c) Other impediments to the functioning of the system.

Confidentiality and Privacy

46) States that the purpose of the system is to learn about and seek to improve public health, population health, social determinants of health, and the health care system, not about individual patients.

47) Requires all policies and procedures developed in implementing this bill to ensure that the privacy, security, and confidentiality of consumers' individually identifiable health information is protected, consistent with state and federal privacy laws, including the

Confidentiality of Medical Information Act (CMIA) and the federal Health Insurance Portability and Accountability Act (HIPAA).

48) Requires OSHPD to develop policies regarding data aggregation and the protection of individual confidentiality, privacy, and security for individual consumers and patients.

49) Exempts individual patient-level data from the disclosure requirements of the California Public Records Act and prohibits this data from being made available except as specified and until OSHPD has developed a policy regarding the release of that data.

50) Requires OSHPD to develop an information security program that uses existing state standards and complies with applicable state and federal laws.

Annual Analysis

51) Requires OSHPD to include in an annual analysis, but shall not limit the content of that analysis to, all of the following:
    a) Population and regional level data on prevention, screening, and wellness utilization;
    b) Population and regional level data on chronic conditions, management, and outcomes;
    c) Population and regional level data on trends in utilization of procedures for treatment of similar conditions to evaluate medical appropriateness;
    d) Regional variation in payment level for the treatment of identified chronic conditions; and,
    e) Data regarding hospital and nonhospital payments, including inpatient, outpatient, and emergency department payments and nonhospital ambulatory service data.

Publicly Available Information & Disclosure Protection/Requirements

52) Requires OSHPD to use the HPD Program data to produce publicly available information, including data products, summaries, analyses, studies, and other reports, to support the goals of the HPD Program. Requires OSHPD to receive input on priorities for the public information portfolio from the advisory committee.

53) Allows OSHPD to establish a pricing mechanism for data products.

54) Allows OSHPD to establish a public liaison function through which individuals may submit requests for specific products or analyses.

55) Allows OSHPD to establish a pricing mechanism for custom reports.

56) Requires OSHPD to maintain copies of custom reports as part of the HPD Program public information portfolio.

57) Allows OSHPD to establish a research program to conduct research, as specified, to support HPD Program policy goals.

58) Requires publicly available data products and reports to protect patient and consumer privacy.

59) Requires all personal consumer information obtained or maintained by the HPD Program to be confidential. States that only deidentified aggregate patient or other consumer data to be included in a publicly available analysis, data product, or research.

60) Requires the system and all HPD Program data to be exempt from the disclosure requirements of the California Public Records Act.

61) Prohibits data from being used for determinations regarding individual patient care or treatment and from being used for any individual eligibility or coverage decisions or similar purposes.

Data Use, Access & Release

62) Requires OSHPD to develop a comprehensive program for data use, access, and release that includes data use agreements that require data users to comply with this bill.

63) States that the purpose of the data use, access, and release program is to ensure that only aggregated, deidentified information is publicly accessible.

64) Requires access to nonpublic data to be governed by the data use, access, and release program.

65) Specifies that to meet the research and policy goals of the HPD Program, controlled access to nonpublic data by outside data analysts, researchers, and other qualified applicants is necessary.

66) Requires OSHPD to establish a secure research environment for access to potentially identifiable information. Requires the environment to include access controls sufficient to ensure that users access only the data specified in an approved data request and that personal information is protected from unapproved use.

67) Requires OSHPD to, with the advice of the advisory committee and data release committee, develop criteria, policies, and procedures for access to and release of nonpublic data. Requires the policies to be designed to recognize a patient's right of privacy and shall include at least the privacy protection standards specified in 70 – 73) below.

68) Requires OSHPD to establish a pricing mechanism for the use of nonpublic data.

69) Requires OSHPD to maintain information about requests and the disposition of requests, and to develop processes for the timely consideration and release of nonpublic data.

Access to NonPublic Data and Security Requirements

70) Requires users, in accessing or obtaining nonpublic data through the secure environment, to only have access to the minimum amount of potentially identifiable data necessary for an approved project or access to a dataset designed for an approved purpose. Requires each person who accesses or obtains nonpublic personal data to sign a data use agreement. States that a violation of a data use agreement is a violation existing provisions of law, as specified.

71) Permits access to data in the secure research environment as follows:

a) If the data does not include any of the direct personal identifiers, as specified, access may be provided to qualified applicants for research and analysis purposes consistent with HPD Program goals.

b) If the data may include any of the direct personal identifiers, as specified, access may be provided only to qualified applicants for research projects that offer significant opportunities to achieve HPD Program goals and meet all of the following criteria:
   i) Project approval has been recommended by the data release committee;
   ii) The project has been approved by the Committee for the Protection of Human Subjects, as specified. Allows OSHPD to release data to established nonprofit research institutions, the University of California, and other nonprofit educational institutions;
   iii) The requester has documented expertise with privacy protection and with the analysis of large sets of confidential data; and,
   iv) The research to be made available to OSHPD.

72) Requires OSHPD to limit release or transmittal of personal information outside the secure environment, as follows:

a) OSHPD may develop standardized limited datasets that do not include any of the direct personal identifiers, as specified, and have the minimum necessary personal information for types of purposes it specified. Allows standardized datasets to be transmitted to qualified applicants if the requester has documented expertise with privacy protection and with the analysis of large sets of confidential data, data security that meet the standards that OSHPD applies to personal data, and project approval has been recommended by the data release committee.

b) Data described in 71) b) ii) (human subjects) may be transmitted to an outside researcher only if the researcher meets all the criteria of that paragraph, the researcher has documented expertise with data security and the protection of large sets of confidential data, and data security will meet the standards that OSHPD applies to personal data.

73) Allows HPD Program data, including personal information, to be shared with other state agencies, as specified.

Data Release Committee

74) Requires OSHPD to establish a data release committee with a membership of at least seven and no more than 11 members appointed by the OSHPD director. States that regardless of existing requirements, a quorum is achieved with one fewer member than one-half of the full membership.

75) Requires the appointed members to include representatives of health care payers, providers, purchasers, researchers, consumers, and labor. Prohibits representatives of the HPD Program submitters from constituting a majority of members. Requires the members to have knowledge and experience with health care data, privacy, and security.

76) Requires each appointed member to serve a term of two years, except one-half of the initial appointments shall be for one year. Authorizes the OSHPD director to remove a member for cause.

77) Requires the data release committee to make recommendations about all applications seeking either HPD Program data with direct personal identifiers or the transmission of standardized datasets, except for data requests from other state agencies. Requires, upon request of the OSHPD director, the data release committee to also make recommendations about other applications for HPD Program data.

78) Requires, upon request of the OSHPD director, the data release committee to generally advise the director about privacy and security matters related to the HPD Program and provide feedback on the HPD Program's data application review processes and other matters.

79) Requires the chairperson of the data release committee to be appointed from among the members by the OSHPD director.

80) Requires a member of the data release committee appointed from outside state government to serve without compensation, but to receive a per diem for each day's attendance at a data release committee meeting. Requires all members to be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the committee.

Funding

81) Requires OSHPD to expend the General Fund (GF) moneys appropriated in the 2018–19 Budget Act for purposes of this bill and the former Health Care Transparency Database to fund the implementation and operation of the HPD Program.

82) Establishes the Health Care Payments Data Fund (fund) within OSHPD for the purpose of receiving and expending revenues collected pursuant to this bill.

83) Requires all revenues collected pursuant to this bill to be deposited in the fund. States that any amounts raised by the collection of the revenues that are not required to meet appropriations in the Budget Act to remain in the fund and to be available to OSHPD in succeeding years upon appropriation by the Legislature.

84) Requires OSHPD to seek to maximize federal financial participation from the Medicaid program for the system, as specified.

85) Authorizes OSHPD to impose a data user fee for an eligible user that is in compliance with this bill, including, but not limited to, provisions related to consumer privacy and data security. Requires the revenue from the data user fee to not exceed OSHPD's administrative costs in providing an eligible user's access to the system.

86) Indicates that state agencies and consumer organizations certified for the consumer participation program administered by the Department of Managed Health Care (DMHC), as specified, are not subject to the user fee but are required to comply with this bill, including, but not limited to, provisions related to consumer privacy and data security.

87) States that upon exhaustion of the GF moneys appropriated in the 2018–19 Budget Act, funding for the actual and necessary expenses of OSHPD in implementing this bill to be provided, subject to appropriation by the Legislature, from transfers of moneys from the Managed Care Fund and the Insurance Fund.

88) States that the share of funding from the Managed Care Fund to be based on the number of covered lives in the state that are covered under plans regulated by the DMHC, including covered lives under MCMC, as determined by the DMHC, in proportion to the total number of all covered lives in the state.

89) States that the share of funding to be provided from the Insurance Fund to be based on the number of covered lives in the state that are covered under health insurance policies and benefit plans regulated by the CDI, including covered lives under Medicare supplement plans, as determined by the CDI, in proportion to the total number of all covered lives in the state.

90) Allows OSHPD to accept foundation funding from foundations not affiliated or controlled by a health care entity.

Enforcement

91) Requires OSHPD to notify the DMHC or the CDI, as appropriate, if a health care service plan or health insurer fails to comply with this bill. Requires the DMHC and the CDI to take appropriate action necessary to bring the plan or insurer into compliance.

92) Makes a violation of the data submission requirements of this bill by health plans a violation of the Knox Keene Plan Act (Knox Keene Act).

Severability

93) States that the provisions of this bill are severable.

EXISTING LAW:

1) Establishes OSHPD, which among other functions, requires each organization that operates, conducts, or maintains a health facility to make and file with OSHPD certain specified reports, including a hospital discharge abstract data record that includes specified elements.

2) Designates OSHPD as the single state agency to collect health facility and clinic data for use by all state agencies. Requires hospitals to make and file with OSHPD certain specified reports, including emergency data records, which contains specified patient information.

3) Requires hospitals to file a Hospital Discharge Abstract Data Record that includes specific patient information such as date of birth; sex; race; ZIP code; Preferred language spoken; patient social security number, principal procedure and date; total charges; expected source of payment; and, other elements added pursuant to regulations.

4) Authorizes OSHPD to allow and provide for additions or deletions to the patient level data elements, as specified.

5) Requires OSHPD, in order to minimize costs and administrative burdens, to consider the total number of data elements required from hospitals and freestanding ambulatory surgery clinics, and optimize the use of common data elements.

6) Requires OSHPD to compile and publish summaries of individual facility and aggregate data that do not contain patient-specific information for the purposes of public disclosure.

7) States legislative intent that OSHPD develop a Health Care Cost Transparency Database to be substantially completed no later than July 1, 2023.

8) Requires OSHPD to convene a Review Committee to advise OSHPD on the establishment, implementation, and ongoing administration of the database specified in 7) above.

9) Requires the Review Committee to submit a report to the Legislature on various elements, including the type of data to be collected for purposes of the database, and entities and individuals who are required to report.

10) Establishes the federal Patient Protection and Affordable Care Act (ACA), which enacts various health care coverage market reforms including the availability of health insurance exchanges, and federal financial assistance in the form of premium assistance or cost sharing reductions to specified eligible individuals.

11) Requires, under the ACA, each state, by January 1, 2014, to establish an exchange that makes qualified health plans (QHPs) available to qualified individuals and qualified employers, in California known as Covered California. Establishes requirements for the exchange and for QHPs participating in the exchange, and defines who is eligible to purchase coverage in the Exchange.

12) Establishes in state government, Covered California, as an independent public entity not affiliated with an agency or department, and requires Covered California to compare and make available through selective contracting health insurance for individuals and small business purchasers as authorized under the ACA. Specifies the powers and duties of the board governing the Exchange, and requires the board to facilitate the purchase of QHPs though the Exchange by qualified individuals and small employers.

13) Requires the board governing Covered California, to make public on the exchange's internet website, plan-specific data on cost reduction efforts, quality improvements, and disparity reductions, as specified

14) Establishes the Employee Retirement Income Security Act) of 1974, to among other provisions, prohibit states from enforcing laws related to private-sector employee health benefit plans.

15) Establishes the Medi-Cal program administered by DHCS, under which qualified low-income individuals receive health care services.

DMHC

16) Establishes the DMHC to regulate health plans under the Knox-Keene Act and CDI to regulate health insurers under the Insurance Code.

17) Authorizes, until January 1, 2024, the DMHC Director to establish the consumer participation program, which allows the DMHC Director to award reasonable advocacy and witness fees to a person or organization that represents consumers and has made a substantial contribution on behalf of consumers to the adoption of a regulation or with regard to an order or decision impacting a significant number of enrollees.

18) Establishes DMHC to regulate health plans and to ensure that health plans provide enrollees with access to quality health care services and protect and promote the interests of enrollees and sets forth application requirements for licensure as a health plan.

19) Defines a health plan or specialized health plan as either of the following: a) any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for, or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees; or, b) any person, whether located within or outside of this state, who solicits or contracts with a subscriber or enrollee in this state to pay for or reimburse any part of the cost of, or who undertakes to arrange or arranges for, the provision of health care services that are to be provided wholly or in part in a foreign country in return for a prepaid or periodic charge paid by or on behalf of the subscriber or enrollee.

20) Requires health plans, if a health plan maintains capitation or risk sharing contracts, to ensure that each contracting provider has the administrative and financial capacity to meet its contractual obligations. Defines a risk bearing organization as a professional medical corporation or other form of corporation controlled by physicians that delivers, furnishes or otherwise arranges for or provides health care services.

21) Authorizes DMHC to exempt certain plans from the Knox-Keene Act, including a self-insured reimbursement plan that pays for or reimburses any part of the cost of health care services, operated by any city, county, city and county, public entity, policy subdivision, or public joint labor management trust that satisfies specified criteria. Exempts any county-operated pilot program contracting with DHCS, as specified.

22) Defines a provider as a hospital, a skilled nursing facility, a comprehensive outpatient rehabilitation facility, a home health agency, a hospice, a clinic, or a rehabilitation agency.

23) Defines a supplier as a physician and surgeon or other health care practitioner, or an entity that furnishes health care services other than a provider.

24) Establishes in the State Treasury, the Managed Care Fund. Requires the administration of DMHC to be supported from the Managed Care Fund.

25) Requires each plan applying for licensure to reimburse the DMHC Director for the actual cost of processing the application, including overhead, up to an amount not to $25,000. Requires each licensed plan to pay to the DMHC Director an amount as estimated by the

DMHC director for the ensuing fiscal year, as a reimbursement of its share of all costs and expenses, in addition to other fees and reimbursements required.

Privacy

26) Establishes HIPAA under federal law, which sets standards for privacy of individually identifiable health information and security standards for the protection of electronic protected health information, including, through regulations, that a HIPAA covered entity may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of an authorization, except under specified circumstances. Provides that if HIPAA's provisions conflict with state law, the provision that is most protective of patient privacy prevails.

27) Prohibits, under the state CMIA, a provider of health care, a health care service plan, a contractor, a corporation and its subsidiaries and affiliates, or any business that offers software or hardware to consumers, including a mobile application or other related device, as defined, from intentionally sharing, selling, using for marketing, or otherwise using any medical information, as defined, for any purpose not necessary to provide health care services to a patient, except as expressly authorized by the patient, enrollee, or subscriber, as specified, or as otherwise required or authorized by law. States that a violation of these provisions that results in economic loss or personal injury to a patient is a crime.

28) Defines personal information as any information that is maintained by an agency that identifies or describes an individual, including, but not limited to, his or her name, social security number, physical description, home address, home telephone number, education, financial matters, and medical or employment history.

29) Makes available, under federal law, Medicare data for the evaluation of the performance of providers of services and suppliers, to qualified entities, defined as a public or private entity that is qualified as determined by the Secretary of the federal Department of Health and Human Services (HHS), to use to evaluate the performance of providers of services and suppliers on measures of quality, efficiency, effectiveness, and resource use, and applies other requirements to qualified entities as the HHS Secretary may specify, such as ensuring security of data.

30) Specifies that any person who willfully requests or obtains any record containing personal information from an agency under false pretenses is guilty of a misdemeanor and fined not more than $5,000, or imprisoned not more than one year, or both.

FISCAL EFFECT: This bill has not yet been analyzed by a fiscal committee

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, health care spending continues to increase, not just nationally but also in California. In California, per-capita spending for all types of health care programs has grown steadily over time for all sources of coverage: employer-sponsored, Medi-Cal, Medicare and private insurance. Many states have established APCDs to collect health insurance claims information from all health care payers into a statewide repository. APCDs are designed to inform cost containment and quality

improvement efforts. The author concludes that as California evaluates efforts to control the growth of health care spending, it is important for the state to have a comprehensive picture of what we pay for in health care. The database will represent the single most important data source to understand health care spending that can eventually lead to cost containment.

2) **BACKGROUND.** AB 1810 (Committee on Budget), Chapter 34, Statutes of 2018, a budget trailer bill, establishes the Legislature's intent for OSHPD to complete by July 1, 2023, a Health Care Cost Transparency Database, to collect information regarding the cost of health care. AB 1810 also required OSHPD to convene a review committee, made up of health care stakeholders and experts to advise OSHPD on the establishment, implementation, and ongoing administration of the database, including a business plan for sustainability without using moneys from the GF. AB 1810 also required OSHPD to submit to the Legislature, by July 1, 2020, a report on the recommendations of the review committee. Furthermore, the 2018-2019 Budget Act appropriated $60 million to establish the Health Care Cost Transparency Database.

   a) **Cost of Health Care.** According to the 2020 "Health Care Priorities and Experiences of California Residents: Findings from the California Health Policy Survey," conducted by the California Health Care Foundation (CHCF) on how California residents view health care policy and their experiences with the health care system, eight out of 10 residents (84%) rate making health care more affordable as an "extremely important" or "very important" priority for the Governor and Legislature to address in 2020. This survey also paints a picture of Californians worried about many types of health care costs, including unexpected medical bills and out-of-pocket expenses. Due to these affordability issues, many residents reported delaying or skipping medical treatment or medications, including cutting pills in half or skipping doses.

      Additionally, 24% of those surveyed reported that they or someone in their family, had problems paying for or were unable to pay medical bills within the past 12 months, and as a result, they have cut back on basic household needs like food and clothing, used up their savings, increased their credit card debt, taken on extra work, borrowed money from friends or relatives, or taken money out of their savings accounts. Although disturbing, the survey results are not surprising. More than half of Californians and their families (58%) obtain their health coverage through their employer, but wages have not kept pace with health spending. According to the UC Berkeley Labor Center (UC Labor Center), since 2008, premiums for job-based family health coverage in California have grown by 49% on average; but real median wages have remained stagnant. For example, single coverage premiums averaged $8,712 per year in 2018, equivalent to $4 per hour for someone working 40 hours per week and for family coverage, the average annual premium was $20,843 which is equivalent to $10 per hour work for a full-time worker, which is $2 less per hour than the current $12 minimum wage for employers with more than 25 employees. In addition to premium costs, consumers are also facing higher out-of-pocket spending. The "Getting to Affordability" report points out that from 2000 to 2016, annual out-of-pocket patient spending increased by almost 36% for those with employer-sponsored coverage or an average annual increase of 2% per year while those with private, individual market coverage had an annual average growth rate of around 4%. The UC Labor Center states that these affordability challenges are causing financial difficulties for those struggling to pay premium or medical bills, deter enrollment in and retention of coverage, and decrease access to care.

According to the National Conference of State Legislatures, options for containing or reducing health care costs and improving efficiency in health care include: creating cost containment commissions, administrative simplification; global or fixed prepayment to health providers; public health promotion; medical homes; combating health care fraud and abuse; prescription drug agreements and volume purchasing; use of generic prescription drugs and brand-name discounts; all-payer rate setting; performance-based health care provider payments; and establishing APCDs.

b) APCDs. APCDs are large-scale databases that systematically collect medical claims, pharmacy claims, dental claims (typically, but not always), and eligibility and provider files from private and public payers. The first statewide APCD system was established in Maine in 2003. By 2008, five states (Kansas, Maine, Maryland, Massachusetts, and New Hampshire) had passed legislation and established APCDs. By the end of 2010, four additional states (Minnesota, Tennessee, Utah, and Vermont) did the same. Since 2010, state interest in APCDs has grown at a steady pace. Currently, 17 states have implemented APCDs and three are implementing, including California.

In an issue brief published by the CHCF entitled "The ABCs of APCDs How States are Using Claim Data to Understand and Improve Care," examples of the ways APCDs are being used by selected states and illuminates issues of critical importance to California, including health care and prescription drug spending trends, opioid use and prescribing patters and the prevalence of chronic disease. The brief points out that numerous states are using their APCDs to understand statewide spending trends and health care cost drivers. For example, in Massachusetts, the Health Policy Commission uses the APCD to create an annual report that examines the trends in health care spending for commercial payers by category of service, and geographic area. These data are used to establish a cost growth target in Massachusetts each year. Rhode Island was able to identify $90 million in potential savings from a reduction in avoidable emergency room visits, and researchers were able to use Virginia's APCD to identify $586 million in unnecessary spending in low-value services. Moreover, analysts in Colorado used its APCD to track EpiPen prescription costs, highlighting an increase of $400 per prescription between 2009 and 2016. Several states have been able to use APCD data to effectively track chronic disease rates and understand more about the costs behind their treatment.

c) Review Committee Report. Pursuant to AB 1810, in March 2020, the review committee submitted its report to the Legislature which included 36 recommendations that were unanimously approved for the HPD Program. The recommendations included:

i) Sources of data, to include Medi-Cal, Medicare, commercial health plans, and insurers for those with employer-based, individual, Medicare Advantage, or dental coverage;

ii) The collection of three years of historical data (enrollment, claims, and encounters, and provider) from submitters;

iii) The collection of non-claims based payments to capture the total cost of care;

iv) Legislation is necessary to authorize data submitters to send and for OSHPD to receive, personal information to meet the Legislative intent of the HPD Program;

v) Mandatory submitters to include health plans and health insurers, the DHCS for MCMC plan and fee for service data; third party administrators of plans, as specified, dental plans and insurers.

vi) Data from required lines of business to include commercial (individual, small group, large group, Medicare Advantage); self-insured plans, as permitted by federal law; dental; and Medi-Cal (FFS and MCMC); and,

vii) To support funding and sustainability, create a special fund for the HPD Program; pursue Center for Medicare and Medicaid Services Medicaid matching funds; establish user fee schedule to support the HDP Program; and explore other revenue sources.

d) Governor's Proposed Trailer Bill Language (TBL). On March 8, 2020, the Governor's Office released a TBL to implement the HPD Program. There are some differences between this bill and the TBL including the following:

i) Mandatory vs. voluntary submitters. This bill requires providers and suppliers to be mandatory submitters beginning January 1, 2026, but the TBL would give OSHPD discretion to collect data from providers and suppliers. Data from providers and suppliers are necessary to provide information on care provided to individuals covered by self-insured plans, which cannot be compelled to submit data because of federal pre-emption.

ii) Conflict of interest. This bill contains conflict of interest requirements for the members of the HPD advisory committee and Bagley-Keen Open Meeting Act requirements, the TBL does not.

iii) Information on health care utilizations. This bill requires the HPD to include detailed information on health care utilization and payments for Californians while the TBL would only authorize this.

iv) Public health impacts. This bill requires specified collection of personally identifiable information to support longitudinal, public health impacts and social determinants of health analyses. The TBL would delete this requirement. Public health impacts and social determinants of health analyses must be conducted in order to reduce disparities and improve quality of care as well as determine impacts on public health.

v) Master patient index, master provider index and master payer index. This bill includes a requirement to develop a master patient index, a master provider index and a master payer index. These indices would allow care to be tracked when a patient changes coverage sources, such as when an individual loses a job and employer health insurance and moves to Covered California or Medi-Cal. It also allows care to be tracked across multiple providers, such as different doctors and hospitals. The TBL does not include this provision.

Additionally, there are provisions in the TBL that were added to this bill, including adding more requirements for the public reporting program, requirements for controlled access to non-public data by outside analysts and researchers, including establishing a

pricing mechanism for use of data; privacy protection standards for the access of non-public data; establishment of a data release committee to make recommendations about applications seeking HPD Program data; and establishes the Health Care Payments Data Fund within OSHPD.

3) **SUPPORT.** Health Access California and SEIU California, supporters of this bill, state that in light of COVID-19, now more than ever, the state needs the HPD Program to ensure a sustainable and affordable health system and oversight and monitoring of health care prices and costs. The Pacific Business Group on Health (PBHG) states that this bill is an important step in institutionalizing APCDs in California, which is vital to the state's cost containment efforts. PBGH asserts that beyond cost transparency, purchasers and consumers have a right to know what their health care dollars are buying. In addition, it is critically important to make quality outcomes available to: a) support accountability among health care providers, b) support payment reform that advances high-value care and, c) inform public policy that improves the health of all Californians. PBGH also notes that the necessity of comprehensive health care cost and quality data has been underscored during the current COVID-19 crisis. A database with robust public use files for purchasers and researchers will be critical not only for public health surveillance, but for developing strategies that transform health care delivery in California.

4) **OPPOSE UNLESS AMENDED.** The California Association of Health Plans and the Association of California Life and Health Insurance Companies have taken an oppose unless amended position and are requesting that this bill be amended to: a) remove the provisions that allow the Managed Care Fund and Insurance Fund to finance the database once state GF dollars are expended, without first exploring whether other revenue sources are adequate; b) inclusion of contracted rates; and, c) revert to the 2023 completion date. The California Medical Association (CMA) has also taken an oppose unless amended position and requests that physicians be removed from the definition of mandatory submitters, and states that delaying the collection of information from physicians to a future date is not sufficient. Additionally, CMA states that further privacy protections must be in place to ensure that access to sensitive information is protected and reserved for organizations that are certified to handle such information for legitimate public health purposes.

5) **CONCERNS.** The California Hospital Association raises the following concerns with this bill: a) the need to revert to the 2023 completion date; b) the HPD Program advisory committee should decide how best to implement the submission of personal health information; c) hospitals should not be mandatory submitters and additional reporting from hospitals would be duplicative and unnecessarily burdensome; and, d) hospitals should be included as qualified applicants for purposes of access to non-public data access.

6) **RELATED LEGISLATION.** AB 2817 (Wood) establishes the Office of Health Care Quality and Affordability (Office) to analyze the health care market for cost trends and drivers of spending, develop data-informed policies for lowering health care costs, and create a strategy to control health care costs. Requires the Office to be governed by a board with specified membership, and requires the board to hire an executive director to organize, administer, and manage the operations of the Office. Requires health care entities to report specified data to the board, which the board would be required to keep confidential. Require the board, based on reported data, to annually establish statewide health care cost growth

targets beginning in the 2022 calendar year and sector-based health care cost growth targets beginning in the 2023 calendar year. AB 2817 is pending in Assembly Health Committee.

7) **PREVIOUS LEGISLATION.** AB 929 (Rivas), Chapter 812, Statutes of 2019, requires the Covered California board to make public on the exchange's internet website, plan-specific data on cost reduction efforts, quality improvements, and disparity reductions, as specified.

8) **AUTHOR'S AMENDMENTS.** To address concerns, the author wishes to amend this bill, as follows:

   a) Revert to the original 2023 completion date of the HPD Program;

   b) Include providers in the definition of qualified applicants;

   c) Require the form that OSHPD is authorized to create for providers and suppliers to not include information that is not available to providers, such as premiums, rebates for outpatient pharmacy, or enrollment in coverage. Requires the form to permit the HPD Program to determine whether a mandatory submitter provided information on the same claim or encounter;

   d) Sunset to January 1, 2026 the provision that allows OSHPD to enter into exclusive or nonexclusive contracts, as specified; and,

   e) Make other, technical, clarifying amendments.

REGISTERED SUPPORT / OPPOSITION:

Support

California Alliance for Retired Americans
California Health Care Coalition
California Labor Federation, AFL-CIO
California Pan - Ethnic Health Network
California State Council of Service Employees International Union
Health Access California
Pacific Business Group on Health
Western Center on Law & Poverty, Inc.

Opposition

None on file.

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