Date of Hearing: April 6, 2021

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
AB 1130 (Wood) – As Introduced February 18, 2021

SUBJECT: California Health Care Quality and Affordability Act.

SUMMARY: Establishes the Office of Health Care Affordability (office) within the Office of Statewide Health Planning and Development (OSHPD) and requires the office to analyze the health care market for cost trends and drivers of spending, create a state strategy for controlling the cost of health care and ensuring affordability for consumers and purchasers, and enforce cost targets. Establishes, within the office, the Health Care Affordability Advisory Board (board) and sets forth the composition and duties of the board, as defined. Specifically, **this bill**:

Defines various terms, including the following:

1) "Affordability for consumers" means considering the totality of costs paid by consumers for covered benefits, including the enrollee share of premium and cost-sharing amounts paid towards the maximum out-of-pocket amount, including deductibles, copays, coinsurance, and other forms of cost sharing.

2) "Affordability for purchasers" means considering the cost to purchasers, including, but not limited to, health plans in the individual market, employers purchasing group coverage, and the state, for health coverage and include premium costs, actuarial value of coverage for covered benefits, and the value delivered on health care spending in terms of improved quality and cost efficiency.

3) "Alternative payment model" means a state or nationally recognized payment approach that rewards high quality and cost-efficient care.

4) "Exempted provider" means a provider that meets standards established by the office for exemption from the statewide, sector-specific, and geographic region cost targets or submitting data directly to the office. Allows the factors used in setting standards for exemption to include, but are not limited to, annual gross and net revenues, patient volume, member months, and market share in a given service or geographic region.

5) "Health care cost target" means the target percentage for the change in total health care expenditures in the state, whether negative or positive.

6) "Material change" means any change in ownership, operations, or governance for a health care entity, involving a material amount of assets of a health care entity.

7) "Net cost of health coverage" or "administrative costs and profits" means the costs associated with the administration of health coverage, and is defined as the difference between the premiums received by a payer and expenditures for covered benefits. States that for health care service plans and health insurers, the net cost of health coverage is derived from all costs not attributable to the numerator of the Medical Loss Ratio (MLR) calculation, as defined.

8) "Payer" means private and public health care payers, including all of the following:
   a) A health care service plan or a specialized health care service plan, as defined;
   b) A health insurer licensed to provide health insurance, as defined;
   c) A publicly funded health care program, including, but not limited to, Medi-Cal and Medicare;
   d) A third-party administrator; and,
   e) Any other public or private entity, other than an individual, that pays or reimburses for any part of the cost for the provision of health care.

9) "Provider" means an individual, organization, or business entity that provides health care services, including, but not limited to, a physician organization or other similar group of providers, health facility, health clinic, including a clinic operated or maintained as an outpatient department of a hospital, or other institutions licensed by the state to deliver or furnish health care services.

10) "Total health care expenditures" means all health care expenditures in the state by public and private sources, including all of the following:
   a) All payments on providers' claims for reimbursement of the cost of health care provided;
   b) All non-claims based payments to providers;
   c) All cost-sharing paid by residents of this state, including, but not limited to, copayments, coinsurance, and deductibles; and,
   d) The net cost of health coverage.

Role of the office

1) Makes the office responsible for analyzing the health care market for cost trends and drivers of spending, developing data-informed policies for lowering health care costs for consumers, creating a state strategy for controlling the cost of health care and ensuring affordability for consumers and purchasers, and enforcing cost targets.

2) Requires the office to do all of the following:
   a) Increase cost transparency through public reporting of total health care spending and factors contributing to health care cost growth;
   b) Establish a statewide health care cost target for per capita spending;
   c) Set specific targets by health care sector, including by payer, provider, insurance market, or line of business, as well as by geographic region;
   d) Collect and analyze data from existing and emerging public and private data sources that allow the office to track spending, set cost targets, approve corrective action plans, monitor impacts on health care workforce stability, and carry out all other functions of the office;
   e) Analyze cost trends in the pharmaceutical sector;
   f) Oversee the state's progress towards the health care cost target by providing technical assistance, requiring public testimony, requiring submission of corrective action plans, and assessing administrative penalties, and including escalating administrative penalties for noncompliance;
   g) Promote and measure quality and health equity through the adoption of a priority set of standard quality and equity measures for assessing health care service plans, health insurers, hospitals, and physician organizations, with consideration for minimizing administrative burden and duplication;

   h) Advance standards for promoting the adoption of alternative payment models;
   i) Measure and promote sustained systemwide investment in primary care and behavioral health;
   j) Advance standards for health care workforce stability and training, as these relate to costs;
   k) Disseminate best practices from entities that comply with the cost target, including a summary of affordability efforts that enable the entity to meet the cost target; and,
   l) Address consolidation, market power, and other market failures through cost and market impact reviews of mergers, acquisitions, or corporate affiliations involving health care service plans, health insurers, hospitals, physician organizations, pharmacy benefit managers, and other health care entities.

3) Allows the office to enter into exclusive or nonexclusive contracts on a bid or negotiated basis, as specified. Exempts these contracts, until January 1, 2026, from specified requirements, including approval by the Department of General Services.

4) Allows, until January 1, 2027, any necessary rules and regulations for the purpose of implementing this bill to be adopted as emergency regulations under the Administrative Procedure Act (APA). Specifies requirements for the emergency regulations.

Data collection

1) Requires the office to collect data and other information it determines necessary from health care entities to carry out its functions. Allows the office to leverage existing and emerging public and private data sources to minimize administrative burdens and duplicative reporting. Allows the office to request data and information from the Department of Managed Health Care (DMHC), the California Department of Insurance (CDI), and other relevant state agencies that monitor compliance of plans and providers with access standards, including timely access, language access, geographic access, and other access standards as provided by law and regulation.

2) Requires the office to establish requirements for payers to submit data and other information necessary to do all of the following:
   a) Measure health care expenditures;
   b) Determine whether health care entities met health care cost targets;
   c) Identify the annual change in health care costs of health care entities;
   d) Approve and monitor implementation of corrective action plans; and,
   e) Assess performance on quality and equity measures.

3) Authorizes the office to establish requirements for providers to submit data as necessary to carry out the functions of the office.

4) Requires payers, for the baseline health care spending report, to submit data on total health care expenditures for the 2021 and 2022 calendar years on or before December 31, 2023. Requires the initial baseline health care spending report to serve as baseline data for measuring the statewide cost target effective for the 2023 calendar year.

5) Requires payers, for subsequent annual reports, commencing with the 2025 calendar year, to submit data on total health care expenditures in the prior calendar year according to the

reporting schedule established by the office.

6) Requires the office to require the following:
   a) Health care service plans, health insurers, hospitals, and physician organizations to report data on the priority set of standard quality measures, as specified, and,
   b) Payers to submit data and other information to measure the adoption of alternative payment models, as specified.

7) Requires the office to establish requirements for payers to report data and other information, including, but not limited to, the types of payment models, the number of members covered by alternative payment models, the percent of budget dedicated to alternative payments, or cost and quality performance measures tied to those payment models.

8) Requires payers to submit data and other information to measure the percentage of total health care expenditures allocated to primary care and behavioral health, as specified.

9) Requires, for the calculation of total health care expenditures allocated to primary care and behavioral health, the office to do all of the following:
   a) Leverage the Health Care Payments Data Program (HPD Program), as specified, to the greatest extent possible to minimize reporting burdens for payers;
   b) Determine the categories of health care professionals who should be considered primary care and behavioral health providers;
   c) Determine specific procedure codes that should be considered primary care and behavioral health services; and,
   d) Determine the categories of non-claims-based payments to primary care or behavioral health care providers and practices, including alternative payment models, that should be included when determining the total amount spent on primary care and behavioral health.

10) Requires providers to submit audited financial reports, consistent with existing requirements, if not already required to submit.

11) Prohibits disclosure of all information and documents obtained pursuant to this bill under the California Public Records Act or any similar local law requiring the disclosure of public records.

12) Requires the office to obtain data from existing state data sources and from regulated entities to effectively monitor impacts to health care workforce stability and training needs.

13) Permits the office to collect all of the following types of workforce data and make it accessible to the public:
   a) Overall trends in the health care workforce, including, but not limited to, statewide and regional workforce supply, unemployment and wage data, trends and projections of wages and compensation, projections of workforce supply by region and specialty, training needs, and other future trends in the health care workforce;
   b) The number and classification of workers in internship, clinical placements, apprenticeships, and other training programs sponsored by an employer;
   c) The percentage of employees employed through a registry or casual employment;
   d) The number of workers at health care entities that were retrained through established public training programs; and,

e) Investments by health care entities in private training and retraining programs.

14) Permits the office to request additional data from health care entities if it finds that the data is needed to effectively monitor impacts to health care workforce stability and training needs.

15) Authorizes the office to annually request from health care entities that are in compliance with the cost target, a summary of best practices used for improving health care affordability, if any.

16) Requires the office to develop reporting schedules, technical specifications, and other resources that support the submission of timely data in a standardized format. Requires the office, prior to adopting regulations and approving the reporting schedules, technical specifications, and other resources, to engage relevant stakeholders and hold a public meeting.

Annual Reports

1) Requires the office, for data submitted for the 2021 and 2022 calendar years, to prepare a report on baseline health care spending on or before June 1, 2024, as specified.

2) Requires the office, on or before June 1, 2025, to prepare and publish an annual report concerning health care spending trends and underlying factors, along with policy recommendations to control costs and improve quality performance and equity of the health care system, while maintaining access to care and high-quality jobs and workforce stability. Requires the report to be based on the office's analysis of data collected under this bill and information received by the office. Requires the first annual report to cover the 2023 calendar year.

3) Requires the annual report to detail all of the following:
   a) Total per capita health care expenditures, disaggregated by service category, consumer out-of-pocket spending, and health care sector, such as payer, provider, insurance market, or line of business, as well as by geographic region;
   b) Beginning with the annual report for the 2023 calendar year, the state's progress towards achieving the health care cost target and improving affordability for consumers and purchasers of health care, while improving quality, reducing health disparities, and maintaining access to care and high-quality jobs and workforce stability;
   c) Upon implementation of the HPD Program or the availability of an alternative source of medical claims data for payers required to report to the office, cost trends by health care sector, such as type of provider or service type. Requires any detailed analysis of cost trends in the pharmaceutical sector to consider the effect of drug rebates and other price concessions in the aggregate, without disclosing any product- or manufacturer-specific rebate or price concession information, and without limiting or otherwise affecting the confidential or proprietary nature of any rebate or price concession agreement;
   d) Factors that contribute to cost growth within the state's health care system;
   e) Access, quality, and equity of care measures and data, as available. Access to include timely access, language access, geographic access, and other measures of access reported through available data;
   f) Corrective action plans required, administrative penalties imposed and assessed, and the amount returned to consumers, if any; and,

g) A summary of best practices for improving affordability, as well as any concerns regarding impacts on the health care workforce stability and training needs of health care workers, as feasible.

4) Requires the office, following the completion of the report on baseline health care spending, to conduct a public meeting to present the report's findings to the board and the broader public. Requires the report on baseline health care spending to be finalized at a subsequent public meeting.

5) Requires the office, on or before June 1, 2025, and each year after, to conduct a public meeting to present the annual report to inform the board, policymakers, including the Governor and the Legislature, and the broader public about implementation of this bill, including health care cost targets, cost trends, and actionable recommendations for mitigating cost growth. Requires the annual report to be finalized at a subsequent public meeting.

6) Permits the OSHPD Director to call for public statements on findings of the annual report from payers, providers, and experts on matters relevant to health care affordability, costs, quality and equity of care, workforce stability, and administrative simplification. Permits the OSHPD Director to solicit and collect comments from the public, submitted orally, electronically, or in writing, regarding any impacts of health care affordability efforts on health care workforce stability or training needs. States that comments may be made anonymously and for all comments to be posted on the office's internet website.

7) Requires the office to notify any relevant regulatory agency if a health care entity is complying with the cost targets by impacting health care workforce stability or quality jobs, lowering quality, or reducing access or equity of care.

8) Requires the annual report and the report on baseline health care spending to be submitted to the Governor and the Legislature, and to be made available to the public on the office's internet website.

9) Requires the public meetings to be subject to the Bagley-Keene Open Meeting Act.

Health Care Affordability Fund

1) Establishes the Health Care Affordability Fund (fund) for the purpose of receiving and expending revenues collected pursuant to this bill, subject to appropriation by the Legislature.

2) Requires all moneys in the fund to be expended in a manner that prioritizes the return of the moneys to consumers and payers.

3) Permits the office to identify any opportunities to leverage existing public and private financial resources to provide technical assistance to health care entities and support to the office. Permits any private or public moneys obtained to be placed in the fund, for use by the office upon appropriation by the Legislature.

Board

1) Establishes, within the office, the board. Requires the board to comprise of nine members, appointed as follows:
   a) Five members to be appointed by the Governor;
   b) Two members to be appointed by the Senate Committee on Rules; and,
   c) Two members to be appointed by the Speaker of the Assembly.

2) Requires the Secretary of the Health and Human Services Agency or their designee to serve as an ex officio member of the board.

3) Requires the Attorney General (AG) to appoint an ex officio member of the board.

4) Requires the members of the board, other than an ex officio member, to be appointed for a term of four years, except that the initial appointment by the Senate Committee on Rules to be for a term of five years, and the initial appointment by the Speaker of the Assembly to be for a term of two years. Permits a member of the board to continue to serve until the appointment and qualification of a successor. Requires vacancies to be filled by appointment for the unexpired term. Requires the Governor to appoint the chair of the board.

5) Requires each person appointed to the board to have demonstrated and acknowledged expertise in at least one of the following areas: health care economics; health care delivery; health care management or health care finance and administration, including payment methodologies; health plan administration and finance; health care technology; competition in health care markets; primary care; behavioral health, including mental health and substance use disorder services; purchasing or self-funding group health care coverage for employees; enhancing value and affordability of health care coverage; organized labor; or, health care consumer advocacy.

6) Requires appointing authorities to consider the expertise of the other members of the board and attempt to make appointments so that the board's composition reflects a diversity of expertise.

7) Requires, in making appointments to the board, the appointing authorities to take into consideration the cultural, ethnic, and geographical diversity of the state so that the board's composition reflects the communities of California.

8) Prohibits a board member from receiving compensation for service on the board, but allows a board member to receive a per diem and reimbursement for travel and other necessary expenses while engaged in the performance of official duties of the board.

9) Requires the board to meet at least quarterly or at the call of the chair.

10) Subjects the board to the Bagley-Keene Open Meeting Act.

11) Subjects the board to the conflict of interest requirements/standards of the Political Reform Act.

12) Requires the board to provide both of the following to the OSHPD Director:

a) A recommended statewide cost target, as specified, approved by a majority vote of the board, and,
b) Specific recommended targets by health care sector and geographic region, as specified, approved by majority vote of the board.

13) Requires the board to advise the OSHPD Director on all of the following:
a) Collection, analysis, and public reporting of data;
b) Factors that contribute to cost growth within the state's health care system, including the pharmaceutical sector;
c) Strategies to improve affordability for both individual consumers and purchasers of health care, including data collection, targets, and other steps;
d) Recommendations for administrative simplification in the health care delivery system;
e) Approaches for measuring access, quality, and equity of care;
f) Setting statewide goals and measuring progress for the adoption of alternative payment models and developing standards that payers and providers can use during contracting;
g) Recommendations for updates to statutory provisions necessary to promote innovation and to enable the increased adoption of alternative payment models;
h) Health care workforce stability and training as these relate to health care costs; and,
i) Addressing consolidation, market power, and other market failures.

Health Care Cost Targets

1) Requires the OSHPD Director to establish a statewide health care cost target for total health care expenditures. Requires this target to be based on the health care cost target recommendation from the advisory board [see 12) a) above], unless either of the following circumstances apply:
a) The OSHPD Director issues a public report that provides justification for using an alternate target, or,
b) The advisory board fails to reach a majority agreement on a recommended statewide health care cost target pursuant 12) a) above.

2) Requires the OSHPD Director, when either of the circumstances in 1) above exists, to establish a statewide health care cost target for total health care expenditures, considering the recommendation from the advisory board, the data received by the office, and the requirements of this bill.

3) Requires the OSHPD Director to set specific targets by health care sector and geographic region. Requires these targets to be based on the health care sector and geographic region target recommendations from the advisory board as specified in 12) b) above, unless either of the following circumstances apply:
a) The OSHPD Director issues a public report that provides justification for using an alternate target;
b) The board fails to reach a majority agreement on a recommended statewide health care cost target pursuant to 12) b) above.

4) Requires the OSHPD Director, when the circumstances in 12) a) or b) above apply, to establish specific targets by health care sector and geographic region, considering the recommendation from the advisory board, the data received by the office, and the requirements of this bill.

5) Allows health care sector to include, but is not limited to, payer, provider, insurance market, or line of business.

6) Requires the office to promulgate regulations for exempted providers with regard to sector-specific targets.

7) States the health care cost target provisions do not exempt claims- and non-claims-based payments for exempted providers, and associated cost-sharing amounts paid by consumers, in the calculation of total health care expenditures submitted by payers.

8) Permits the OSHPD Director to adjust cost targets by individual health care entity, when warranted, to account for that entity's baseline costs in comparison to other health care entities in a region or health care sector.

9) Requires targets set for payers to also apply to the net cost of health coverage to deter growth in administrative costs and profits.

10) Requires the setting of different targets to be informed by historical cost data and other relevant data, as well as access, quality, equity, and health care workforce stability and quality jobs, as specified.

11) Requires the health care cost targets to meet all of the following requirements:
    a) Promote a predictable and sustainable rate of change in total health care expenditures;
    b) Be based on established economic indicators reflecting the broader economy and labor market;
    c) Be met by health care entities in the state;
    d) Be annually reviewed and updated;
    e) Be developed, applied, and enforced with consideration of multiple year rolling averages; and,
    f) Improve affordability for consumers and purchasers of health care.

12) Requires the OSHPD Director to establish a methodology to set health care cost targets, including adjustment factors and the economic indicators to be used in establishing the target.

13) Requires the targets established for a payer's net cost of health coverage to be subject to annual adjustment, but to not increase to the extent the costs for the medical care portion of the MLR exceed a target.

14) Requires the OSHPD Director to direct the public reporting of performance on the health care cost targets, which may include analysis of changes in total health care costs on an aggregate and per capita basis for any or all of the following:
    a) Statewide;
    b) By geographic region;
    c) By insurance market and line of business;
    d) For payers and providers, both unadjusted and using a standard risk adjustment methodology; and,
    e) For impact on affordability for consumers and purchasers of health care.

15) Requires the OSHPD Director, for the 2023 calendar year and each calendar year thereafter, to establish a statewide health care cost target, as specified. Requires the 2023 calendar year to be a reporting year only, and beginning in the 2024 calendar year, applicable cost targets to be enforced for compliance, as specified.

16) Requires the OSHPD Director, no later than the 2025 calendar year, to set specific targets by health care sector and geographic region.

17) Requires the OSHPD Director, following the board's delivery of recommendations for statewide, sector-specific, or geographic region cost targets, to hold a public meeting to discuss the recommendations. Requires the OSHPD Director to consider the recommendations of the board and public comment. States that cost targets and other decisions of the OSHPD Director to not be adopted, enforced, revised, or updated until presented at a subsequent public meeting which are subject to the Bagley-Keene Open Meeting Act.

18) Exempts the adoption of cost targets from the requirements of the APA, as specified.

Enforcement

1) Requires the OSHPD Director to enforce the cost targets against health care entities in a manner that both ensures compliance with targets and allows each health care entity opportunities for remediation. Requires the OSHPD Director to consider each entity's contribution to cost growth in excess of the applicable target and the extent to which each entity has control over the applicable components of its cost target.

2) Permits the OSHPD Director, commensurate with the health care entity's offense or violation, to take the following progressive enforcement actions:
   a) Provide technical assistance to the entity to assist it to come into compliance;
   b) Require public testimony by the health care entity regarding its failure to comply with the target;
   c) Require submission and implementation of corrective action plans; and,
   d) Assess administrative penalties in amounts initially commensurate with the failure to meet the targets, and in escalating amounts for repeated or continuing failure to meet the targets.

3) Requires the office, if a health care entity exceeds an applicable cost target, to notify the entity of their status and provide technical assistance. Permits the office to require a health care entity to submit and implement a corrective action plan that identifies the causes for spending growth and to include, but not be limited to, specific strategies, adjustments, and action steps the entity proposes to implement to improve spending performance during a specified time period. Requires the office to request further information, as needed, in order to approve a proposed corrective action plan.

4) Requires the office to monitor the health care entity for compliance with the corrective action plan. Requires the office to publicly post the identity of a health care entity completing a corrective action plan while the plan remains in effect and to transmit an approved corrective action plan to appropriate state regulators for the entity.

5) Requires a health care entity to work to implement the corrective action plan as submitted to, and approved by, the office. Requires the office to monitor the health care entity for compliance with the corrective action plan.

6) Permits the OSHPD Director, if the office determines a corrective action plan is not appropriate or if the health care entity does not meet the cost target after the implementation of a corrective action plan, the OSHPD Director to assess administrative penalties commensurate with the failure of the health care entity to meet the target.

7) Permits an administrative penalty to be an amount up to the health care entity's spending in excess of the health care cost target and to be deposited into the fund.

8) Allows the OSHPD Director to assess escalating administrative penalties if, after the implementation of one or more corrective action plans, the health care entity repeatedly exceeds the cost target.

9) Requires the office to consider the nature and number of offenses in determining the amount of the administrative penalty.

10) Prohibits administrative penalties from constituting as expenditures for the purpose of meeting cost targets. States that the imposition of administrative penalties to not alter or otherwise relieve the health care entity of the obligation to meet a previously established cost target or a cost target for subsequent years.

11) Requires the OSHPD Director, for payers, to enforce cost targets against the cost growth for the net cost of health coverage.

12) Requires a payer, if a payer exceeds the target for total health care expenditures, but has met its target for the net cost of health coverage, to submit relevant documentation or supporting evidence for the drivers of excess cost growth. Requires the office to review this information to determine the appropriate health care entity that may be subject to enforcement actions.

13) Permits the OSHPD Director at any point to require that a cost and market impact review be performed on a health care entity, as specified, if data from multiple sources indicate adverse cost impacts from consolidation, market power, or other market failures.

14) Permits the OSHPD Director to assess administrative penalties when a health care entity has failed to comply with the enforcement process by doing any of the following:
    a) Willfully failing to report complete and accurate data;
    b) Neglecting to file a corrective action plan with the office;
    c) Failing to file an acceptable corrective action plan with the office;
    d) Failing to implement the corrective action plan;
    e) Knowingly failing to provide information required by this section to the office; and,
    f) Knowingly falsifying information required by this bill.

15) Requires the office to consider the nature and number of offenses in determining the amount of the administrative penalty.

16) Requires the OSHPD Director to refer a payer who has failed to comply with enforcement procedures to the respective regulator. States that failure to comply with enforcement procedures constitutes a violation of the licensing law applicable to the payer and subject to all civil, administrative, and equitable, but not criminal, remedies.

17) Permits the OSHPD Director to call a public meeting to notify the public about a health care entity's violation and declare the entity as imperiling the state's ability to monitor and control health care cost growth.

18) Allows the office to establish requirements for health care entities to file for a waiver of enforcement actions under extraordinary circumstances, such as an act of God or catastrophic event. Requires an entity to submit documentation or supporting evidence of extraordinary circumstances. Requires the office to request further information, as needed, to approve or deny an application for a waiver.

19) Permits a health care entity adversely affected by a final order imposing an administrative penalty to seek independent judicial review, as specified. Specifies other requirements for the administrative penalty consistent with existing law.

Quality and Equity Performance

1) Requires the office to adopt a priority set of standard measures for assessing health care quality and equity among health care service plans, health insurers, hospitals, and physician organizations. Requires the performance on quality and health equity measures to be included in the annual report.

2) Requires the standard quality and equity measures to do the following:
   a) To use recognized clinical quality, patient experience, patient safety, and utilization measures for health care service plans, health insurers, hospitals, and physician organizations;
   b) To reflect the diversity of California in terms of race, ethnicity, gender, age, language, sexual orientation, and gender identity. Requires the standard quality and equity measures to be appropriate for a population under 65 years of age, including children and adults; and,
   c) To consider available means for reliable measurement of disparities in health care, including race, ethnicity, gender, age, language, sexual orientation, and gender identity.

3) Requires the office to reduce administrative burden by selecting quality and equity measures that simplify reporting and align performance measurement with other payers and programs.

4) Requires the office to consult with state departments, external quality improvement organizations and forums, payers, physicians, and other providers in implementing the quality measures provisions.

5) Requires the office to annually review and update the priority set of standard measures for assessing the quality and equity of care pursuant to 1) above.

Alternative Payment Models

1) Requires the office to promote the shift from payments based on fee-for-service (FFS) to those rewarding high quality and cost-efficient care. Requires the office to set statewide goals for the adoption of alternative payment models and measure the state's progress toward those goals.

2) Requires the office, on or before July 1, 2023, to adopt standards for alternative payment models that may be used by providers and payers when contracting.

3) Requires the standards for alternative payment models to focus on improving affordability, efficiency, equity, and quality by considering the current best evidence for strategies such as investments in primary care and behavioral health, shared risk arrangements, or population-based payments.

4) Requires the standards to do the following:
   a) Include minimum criteria for what is considered an alternative payment model, but be flexible enough to allow for innovation and evolution over time;
   b) Address appropriate incentives to physicians and other providers and balanced measures, including total cost of care and quality and equity requirements, to protect against perverse incentives and unintended consequences; and,
   c) Attempt to reduce administrative burden by incorporating alternative payment models that align with other payers and programs or national models.

5) Requires the office to conduct an analysis of alternative payment model, as specified.

6) Requires the office, in implementing the above provisions, to consult with state departments, external organizations promoting alternative payment models, and other entities and individuals with expertise in health care financing and quality and equity measurements.

Primary Care and Behavioral Health Investments

1) Requires the office to measure and promote a sustained systemwide investment in primary care and behavioral health. Requires the office to measure the percentage of total health care expenditures allocated to primary care and behavioral health and set spending benchmarks.

2) States that the intent of the spending benchmarks is to build and sustain infrastructure and capacity for primary care and behavioral health without increasing costs to consumers or increasing the total costs of health care.

3) Requires the office to promote improved outcomes for primary care and behavioral health, including, but not limited to, health care entities making investments in, or adopting models that do, any or all of the following:
   a) Increase access to advanced primary care models;
   b) Integrate primary care and behavioral health services;
   c) Leverage alternative payment models that provide resources at the practice level to enable improved access, care coordination, patient engagement, quality, and population health; and,

d) Deliver higher value primary care and behavioral health services with an aim toward reducing disparities.

4) Requires the office to include an analysis of primary care and behavioral health spending and growth, and relevant quality and equity performance measures, in the annual report.

5) Requires the office to consult with state departments, external organizations promoting investment in primary care and behavioral health, and other entities and individuals with expertise in primary care, behavioral health, and health equity in implementing the above provisions.

Health Care Workforce Stability

1) Requires the office to monitor health care costs while promoting health care workforce stability and the professional judgment of health professionals, acting within their scope of practice. Requires the office to monitor health care workforce stability with the goal that workforce shortages do not undermine health care affordability. Requires the office to promote the goal of health care affordability, while recognizing the need to maintain and increase the supply of trained health care workers.

2) Requires the office, to assist health care entities in implementing cost-reducing strategies that advance the stability of the health care workforce, and without exacerbating existing health care workforce shortages, on or before July 2023, in consultation with the board, to develop standards to advance the stability of the health care workforce. Allows the standards to be considered in the approval of corrective action plans, as specified.

Health Care Market Trends

1) Requires the office to monitor cost trends, including conducting research and studies, on the health care market, including, but not limited to, the impact of consolidation, market power, and other market failures on competition, prices, access, quality, and equity.

2) Specifies that in collaboration with the AG, DMHC, and CDI, as appropriate, the office to promote competitive health care markets by examining mergers, acquisitions, corporate affiliations, or other transactions that entail a material change to ownership, operations, or governance structure involving health care service plans, health insurers, hospitals or hospital systems, physician organizations, pharmacy benefit managers, and other health care entities.

3) Requires a health care entity to provide the office with written notice of agreements or transactions that will occur on or after April 1, 2023, that do either of the following:
   a) Sell, transfer, lease, exchange, option, encumber, convey, or otherwise dispose of a material amount of its assets to one or more entities; or,
   b) Transfer control, responsibility, or governance of a material amount of the assets or operations of the health care entity to one or more entities.

4) Requires the written notice specified in 3) above to be provided to the office at least 90 days prior to entering into the agreement or transaction. Requires the office, upon receipt of a written notice to make the notice of material change publicly available.

5) Requires the office to adopt regulations for proposed material changes that warrant a notification, establish appropriate fees, and consider appropriate thresholds, including, but not limited to, annual gross and net patient revenues and market share in a given service or region.

6) Exempts from the notice requirement the following:
   a) Agreements or transactions involving health care service plans that are subject to review by the Director of the DMHC, as specified;
   b) Agreements or transaction involving health insurers that are subject to review by the Insurance Commissioner (IC), as specified;
   c) Agreements or transactions involving health care entities under the control of, and operated by, a political subdivision; and,
   d) Agreements or transactions involving nonprofit corporations that are subject to review by the AG.

7) States that agreements or transactions exempted under 6) above to provide a notice of material change may be referred to the office for a cost and market impact review by the reviewing authority.

8) States that the above provisions does not limit the AG's review of the conversion or restructuring of charitable trusts held by a nonprofit health facility or by an affiliated nonprofit health system.

9) States that if the office finds that a material change noticed pursuant to the above provisions is likely to have a significant impact on market competitions, the state's ability to meet cost targets, or costs for purchasers and consumers, the office to conduct a cost and market impact review that examines factors relating to a health care entity's business and its relative market position, including, but not limited to, changes in size and market share in a given service or geographic region, prices for services compared to other providers for the same services, quality, equity, cost, access, or any other factors the office determines to be in the public interest.

10) Authorizes the office to conduct cost and market impact reviews on any health care entity determined by the OSHPD Director under subdivision (e) of Section 127502.5, or in association with agreements or transactions referred to the office by a reviewing authority listed in paragraphs (1) to (4), inclusive, of subdivision (c) of Section 127507. An agreement or transaction for which a cost and market impact review proceeds under this section shall not be implemented without a written waiver from the office or until 30 days after the office issues a final report.

11) Requires the office, within 60 days of receipt of a notice of material change, to either advise the noticing health care entity of the office's determination to conduct a cost and market impact review or provide a waiver or conditional waiver. Allows a health care entity 30 days to object to a conditional waiver in writing, and the office to proceed with a cost and market impact review upon receipt of a written objection.

12) Requires the office, in furtherance of the above provisions to conduct investigations, including, but not limited to, compelling, by subpoena, health care entities and other relevant market participants to submit data and documents.

13) Requires the office, upon completion of the cost and market impact review, to make factual findings and issue a preliminary report of its findings. States that after allowing for the affected parties and the public to respond in writing to the findings in the preliminary report, the office to issue its final report.

14) Requires the office to adopt regulations for notification to affected parties for the basis of the review, factors considered in the review, requests for data and information from affected parties, the public, and other relevant market participants, and relevant timelines.

15) Requires the office to keep confidential all nonpublic information and documents obtained that were not required with the notice of material change, and to not disclose the confidential information or documents to any person, other than the AG, without the consent of the source of the information or documents, except in a preliminary report or final report, if the office believes that disclosure should be made in the public interest after taking into account any privacy, trade secret, or anticompetitive considerations.

16) States that all nonpublic information and documents obtained as part of the cost and market impact review is not required to be disclosed pursuant to the California Public Records Act, or any similar local law requiring the disclosure of public records.

17) Permits the office to refer its findings, including the totality of documents gathered and data analysis performed, to the AG for further review of unfair methods of competition or anticompetitive behavior.

18) States the provisions relating to the cost and market impact review do not limit the authority of the AG to protect consumers in the health care market under any other state law.

19) Permits the office to do the following:
    a) Contract with, consult, and receive advice from any state agency on terms and conditions that the office deems appropriate; and,
    b) Contract with experts or consultants to assist in reviewing a proposed agreement or transaction.

20) States that contract costs pursuant to 19) above to not exceed an amount that is reasonable and necessary to conduct the review and complete the report.

21) Entitles the office to reimbursement from the health care entity subject to review for all actual, reasonable and direct costs incurred in reviewing, evaluating, and making the determination, including administrative costs. Requires a health care entity subject to review to promptly pay the office, upon request, for all of those costs.

22) States that in addition to any legal remedies, the office is entitled to specific performance, injunctive relief, and other equitable remedies a court deems appropriate for enforcement of any of the requirements of this article and shall be entitled to recover its attorney's fees and costs incurred in remedying each violation.

Severability

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) Establishes DMHC to regulate health care service plans and CDI to regulate health insurance.

4) Requires every health plan and health insurer that issues, sells, renews, or offers health plan contracts or insurance policies for health care coverage, including a grandfathered health plan or insurer, but not including specialized health plan contracts or insurance policies, to provide an annual rebate to each enrollee or insured under such coverage if the ratio of the amount of premium revenue expended by the health plan or insurer on the costs for reimbursement of clinical services provided to enrollees or insureds, as specified, to the total amount of premium revenue less certain taxes and fees is less than the following:
   a) Eighty-five percent for a health plan or health insurer in the large group market; or,
   b) Eighty percent for a health plan or health insurer in the small group or individual market.

5) Requires the plans and insurers in 4) above to comply with the following minimum MLR:
   a) Eighty-five percent for a health plan or health insurer in the large group market; or,
   b) Eighty percent for a health plan or health insurer in the small group or individual market.

6) Requires prior approval by the DMHC Director for a health plan that intends to merge or consolidate with, or enters into an agreement resulting in its purchase, acquisition or control by, any entity and allows the DMHC Director to disapprove a transaction if the transaction would substantially lessen competition.

7) Establishes under federal law, the Federal Trade Commission (FTC) to enforce the antitrust laws in health care markets to prevent anticompetitive conduct that would deprive consumers of the benefits of competition.

8) Permits the IC to deny a permit in any case where a domestic insurer is directly affected by a transaction of which the permit applied for is needed, if it is determined that reasonable grounds exist that the transaction:
   a) Is a combination of capital, skill, or acts to create or carry out restrictions on or to prevent competition in the insurance business;
   b) Is a combination (in the form of a trust or otherwise) in restraint of the insurance business;
   c) Is an attempt to monopolize the insurance business;
   d) Is a conspiracy to create any of the foregoing; or,
   e) That such total transaction, or any part thereof, if consummated will create or result in any of the foregoing or will substantially lessen competition in the insurance business.

9) Establishes the state Department of Justice and the AG to bring civil and criminal legal actions against individuals and businesses acting in restraint of trade under the Cartwright

Act, which is the state's antitrust law prohibiting anti-competitive activity, mirroring the federal Sherman Antitrust Act and the Clayton Antitrust Act.

10) Requires any non-profit corporation that operates or controls a health facility, regardless of whether it is currently operating or providing health care services or has a suspended license, to provide written notice to, and obtain the written consent of, the AG prior to entering into any agreement or transaction to do either of the following:
    a) Sell, transfer, lease, exchange, option, convey, or otherwise dispose of, its assets to a for-profit corporation or entity, or another non-profit corporation; or,
    b) Transfer control, responsibility, or governance of a material amount of the assets or operations of the non-profit corporation to any for-profit corporation or entity, or another non-profit corporation.

11) Requires the AG, within 90 days of the receipt of a written notice of a proposed transaction involving a non-profit health facility, to notify the non-profit corporation in writing of the decision to consent to, give conditional consent to, or not consent to the agreement or transaction. Permits the AG to extend the 90-day deadline for one additional 45-day period if any of the following conditions are satisfied: the extension is necessary to obtain specified information; the proposed transaction is substantially modified after the first public meeting conducted by the AG; or, the proposed transaction involves a multi-facility health system serving multiple communities.

12) Grants the AG the discretion to consent to, give conditional consent to, or not consent to any agreement or transaction involving a nonprofit health facility based on the consideration of any factors that the AG deems relevant, including, but not limited to whether or not the terms and conditions of the agreement or transaction are fair and reasonable to the nonprofit corporation, the agreement or transaction is at fair market value, or the agreement or transaction may create a significant effect on the availability or accessibility of health care services to the affected community.

13) Prohibits the AG from consenting to any agreement in which the seller restricts the type or level of medical services that may be provided at the health facility.

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

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, health care spending is growing faster than wages and consumers are feeling the pinch. Many Californians are having problems paying for their medical bills and are forced to forego or sacrifice basic necessities like food, clothing and are using up their savings, taking on more credit card debt, working extra or borrowing money so that they can get and pay for the health care that they need. There is also a disturbing trend where consumers are paying higher out of pocket costs every year. Given all this, it is not surprising that in a survey conducted last year, eight out of 10 California residents rate making health care more affordable as an extremely important or very important for the Governor and Legislature to address. This bill establishes the office to develop statewide and sector benchmarks, analyze health care market for cost trends and drivers of spending, developing policies and strategies for lowering health care costs, and ensuring affordability for consumers and purchasers, and enforcing cost targets.

2) **BACKGROUND**. Total healthcare expenditures in the United States in 2019 reached $3.8 trillion, or $11,582 per person, up from 2018 when total national health expenditures were $3.6 trillion, or $11,129 per person. Private health insurance spending (31% of total health care spending) increased 3.7% to $1.2 trillion in 2019, which was slower than the 5.6% rate of growth in 2018. Medicare spending (21% of total health care spending) grew 6.7% to reach $799.4 billion in 2019, which was slightly faster than the 6.3% growth in 2018. Medicaid spending (16% of total health care spending) increased 2.9% in 2019 to reach $613.5 billion. Out-of-pocket spending (11% of total health care spending at $406.5 billion in 2019) includes direct consumer payments such as copayments, deductibles, and spending not covered by insurance. Out-of-pocket spending grew 4.6% in 2019, which was faster than the 3.8% growth in 2018.

   a) **Health Care Spending in California**. According to a report entitled "An Environmental Analysis of Health Care Delivery, Coverage, and Financing in California" submitted by the Healthy California for All Commission to the Legislature in August 2020, in 2018, California's total health expenditures were an estimated $399.2 billion which accounted for 13.2% of the state's Gross Domestic Product which was $3.018 trillion. California's per capita health care spending in 2018 was $10,086. Similar to the federal data, the major payers for health care in California were private insurance (32.2%), Medicare (19.6%) Medi-Cal (18.5%) and other (29.7%).

      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.

      A CHCF report entitled, "Getting to Affordability: Spending Trends and Waste in California's Health Care System," 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.

   b) **How Critical is Health Care Affordability to Consumers?** According to the 2020 "Health Care Priorities and Experiences of California Residents: Findings from the California Health Policy Survey," conducted by 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.

c) Cost Containment Commissions. The growth in health care spending and affordability challenges are not unique to California; many states are exploring multiples ways to control spending, and one method is through the creation of cost containment commissions. According to a January 2020 CHCF report entitled "Commissioning Change: How Four States Use Advisory Boards to Contain Health Spendin*g*," cost-containment commissions establish targets to make health care more affordable to consumers and improve the delivery of care.

In 2012, Massachusetts established the Health Policy Commission, the first program to monitor health care spending growth in Massachusetts and provides data-driven policy recommendations regarding health care delivery and payment system reform. From 2013-2017, the benchmark must be set equal to the growth rate of potential state product (PGSP) or 3.6%. From 2018 to 2020, the benchmark is equal to PGSP minus 0.5% or 3.1%. According to a 2020 case study by the Commonwealth Fund, from 2013 through 2017, annual growth in total health care expenditures in Massachusetts fell below the benchmark of 3.6% for three years and exceeded it for two years, yielding a five-year annual average of 3.4%. In 2018, estimated statewide spending growth equaled a revised benchmark of 3.1%. In the commercial sector, slower spending growth meant that employers and consumers paid an estimated $7.2 billion less from 2013 to 2018 than they would have if the state's spending growth had matched the national average.

Other states like Delaware, Rhode Island, Oregon, Connecticut, and Washington have now established their own cost containment commissions.

d) Health Payments Database. AB 80 (Committee on Budget), Chapter 12, Statutes of 2020, requires OSHPD to create and administer a statewide HPD Program and have the database completed by July 1, 2023. Under AB 80, mandatory submitters, defined to include health care plans and insurers are to provide health care data, including claim and encounter, member enrollment, provider and supplier information, nonclaims-based payments, premiums, and pharmacy rebate data, including pricing information for health care items, services, and medical and surgical episodes of care gathered from payments for covered health care items and services. The Department of Health Care Services, for those enrolled in Medi-Cal and other insurance affordability programs, whether enrolled in Medi-Cal managed care, FFS Medi-Cal, or any other payment arrangement is also a mandatory submitter to the HPD.

The timeline below was provided by OSHPD for HPD implementation:

Projected Time	Period Project Activities
July to December 2020	➢ Stakeholder engagement, including finalizing common data specifications with national AllPayer Claims Database Council. ➢ Beginning of rulemaking process. ➢ Convene HPD Advisory Committee. ➢ Convene HPD Data Submitter Workgroup.
January to December 2021	➢ Technology contracting for data collection. ➢ Design and develop database technology solutions. ➢ Completion of rulemaking process to establish emergency regulations for data submission requirements.
January to December 2022	➢ Regulations take effect. ➢ Begin limited data collection and perform initial data quality and evaluation activities. ➢ Finalize database technology solutions.
January to June 2023	➢ Submit report to the Legislature with recommendations for funding options for the HPD program. ➢ Continue data quality and evaluation activities. ➢ Finalize data collection and complete database technical infrastructure.
July to December 2023	➢ Begin producing initial analytic reports from the database

e) Governor's Budget. In the 2020-21 Budget, the Governor proposed the creation of the office but due to the COVID-19 pandemic, this proposal was delayed. In the 2021-22 Budget, the Governor reintroduced the creation of the office and published a trailer bill language which is identical to this bill. Additionally, the 2021-22 Budget also proposes staffing requests for the creation of the office.

f) Informational Hearings. In March and October 2020, the Assembly Health Committee conducted two informational hearings on cost containment and explored options on controlling costs in California.

3) AUTHOR'S AMENDMENTS. To address concerns raised by stakeholders, the author proposes various amendments, including the following:

Pharmaceuticals

a) Requires the office to consider data in the report required by SB 17 (Hernandez), Chapter 603, Statutes of 2017, and pharmaceutical data reported to the HPD when analyzing pharmaceutical spending trends.

b) Clarifies that the office may enter into data sharing agreements with state agencies on existing data sources.

Reporting Requirements

c) Requires, for the purpose of publicly reporting the impact of COVID-19 on health care spending, payers to submit aggregate data on total health care expenditures for the 2019, 2020, and 2020 calendar years on or before December 31, 2022. Specifies that no

enforcement will be implemented for this report. Requires the office to prepare a report based on these data on or before June 1, 2023.

d) Requires, for the purpose of baseline health care spending, payers to submit data on total health care expenditures for the years 2022 and 2023 calendar years on December 31, 2024. Specifies that no enforcement for the targets established under this baseline report will be implemented. Requires the office to prepare a report on baseline health care spending on or before June 1, 2025.

e) Requires, for the first annual report, payers to submit data on total health care expenditures for the year 2024 on or before December 31, 2025. Requires payers, for subsequent annual reports, to submit data according to the reporting schedule established by the office. Requires the office to prepare the first annual report for the 2024 calendar year on or before June 1, 2026.

f) Requires payers and providers to submit data and other information necessary to measure total health care expenditures.

g) Requires the office to use the HPD to the greatest extent possible to minimize reporting burdens.

h) States that the requirement to submit audited financial report does not apply to exempted providers.

i) Requires the office to enter into data sharing agreements with state agencies, as specified and specify that alternative sources of data include data provided to other state agencies.

Use of Funds

j) Prohibits using funds collected under this bill from being used for operational expenses of the office except for funding improvements in the health care delivery system.

Board Appointments

k) Increases the membership of the board by two members (bringing the total membership of the board to 11 members), as follows:
- **i)** Requires the Governor to appoint at least one purchaser of health care coverage or benefits who also has expertise in health care delivery, management, financing or administration; and,
- **ii)** Adds the California Public Employees' Retirement System Chief Health Director or their designee.

l) Requires one of the Governor's appointees to be a health economist.

Health Care Cost Targets

m) Clarifies that the OSHPD Director may adjust cost target by geographic region, sectors and subsectors.

n) Requires the health care cost targets to consider relevant adjustment factors.

o) Requires the office by 2026 to define the parameter of geographic regions and health care sectors, including any stratification by subsector, such as delivery system characteristics or beneficiary-risk factors, including but not limited to, academic medical centers, public hospitals serving disproportionate share of low-income and uninsured consumers, or fully integrated systems.

p) Extends to 2027 the time for the OSHPD Director to set health care sector and geographic region targets.

q) Requires the public report issued by the OSHPD Director which provides justification for using an alternate target to demonstrate that the alternate target would result in greater cost savings to health care consumers than the target recommended by the advisory board, without reducing the quality of care, as specified.

r) Requires the board to provide recommendation on the parameters of healthcare sector and geographic region, including any stratification by subsector, as specified.

Enforcement

s) States that the intent of the Legislature in enacting this bill is for the enforcement actions to be implemented in a progressive manner, such that health care entities are assisted with coming into compliance with meeting statewide and sector cost targets, including through technical assistance and corrective actions before assessing administrative penalties unless there are egregious violations.

t) Clarifies that administrative penalties may be assessed for repeatedly neglecting to file a corrective action plan; repeatedly failing to file an acceptable corrective action plan; or, repeatedly failing to implement the corrective action plan.

Quality and Equity Performance

u) Requires the office, to reduce administrative burden, to leverage existing, voluntary and required reporting, such as the National Quality Forum clinical quality composite measures, to the greatest extent possible.

v) Requires the office to also consult with consumer advocate or stakeholders with expertise in quality or equity measurement.

Alternative Payment Models

w) Requires the office to review the standards at least every five years or less as appropriate to determine whether the standards are rewarding high quality, cost-efficient and equitable care.

x) Requires the spending benchmarks for primary care to consider current and historic underfunding of primary care services.

Health Care Workforce Stability

y) States that the office in promoting the goal of health care affordability to recognize the need to maintain and increase the supply of trained health care workers and to respecting collective bargaining agreements involving health care workers.

Health Care Market Trends

z) Specifies that nothing in the provisions relating to health care market trends displaces the existing authority of the AG under federal or state laws.

4) SUPPORT. The Western Center on Law and Poverty, California Rural Legal Assistance, California Pan Ethnic Health Network, Children Now, and Justice in Aging, write in support that Californians are being crushed by the high cost of health care, and the office provides a realistic and practical approach to tackling this complex issue. Supporters state that the office, with a comprehensive look at the health system, would have the best potential to ensure that the benefit of reforms actually reaches consumers, employers, workers, and taxpayers. Blue Shield states that it supports this bill's goal of analyzing, identifying, and reigning health care costs while increasing quality and price transparency.

The California Labor Federation, Health Access of California, Small Business Majority, and the Purchaser Business Group on Health support the creation of the office that would set and enforce cost targets while providing the health industry the tools it needs to improve quality and equity, shift to alternative payment methods, emphasize primary care and behavioral health while preserving the stability of the health care workforce. These supporters also seek amendments to assure that a clear majority of the advisory board represent consumers and purchasers of health coverage.

5) SUPPORT IF AMENDED. The America's Physician's Groups supports cost and quality transparency but suggests that a description of total cost of care be included; that all health care entities are measured and reported; the inclusion of employer, payer, provider and patient elements of the market; monitoring and assessment of employer plan offerings within each market; the inclusion of DMHC and CDI existing financial reporting standards; and, prohibiting the office from using fines and penalties collected to fund operational budgets.

The California Chamber of Commerce (Chamber) requests that this bill, to the extent possible, utilize existing data submission standards and formats to avoid increasing administrative costs. The Chamber also states that the office should rely on existing reporting mechanisms if they exists and that investment in primary health should include investments in telehealth, community health workers, and facilities that address chronic disease management.

The California Medical Association (CMA) states it supports the adoption of and movement of more patients into value-based payment methods using alternative payment methods but requests a more focused definition of provider for purposes of physicians and it believes that setting the cost target should be given to the Governor or the IC. Additionally, CMA points out that using 2021 and the immediate subsequent years as base-year information for setting the targets could give an inaccurate picture of the health care market, its care outcomes, and costs. CMA also questions the need for audited financial reports and this bill must address the administrative complexities that exist within the system to streamline quality reporting requirements for physician practices.

6) **OPPOSE UNLESS AMENDED**. The California Children's Hospital Association, MemorialCare, Dignity Health, and several hospitals have taken an oppose unless amended position and state that this bill must be amended to establish a public commission comprised of experts who can take on key issues and advise the Legislature and the administration on developing a framework and process that will address health care affordability in California.

7) **PREVIOUS LEGISLATION.** AB 2817 (Wood) of 2020 would have established the office as an independent public entity within state government. AB 2817 was held by the author due to the shortened Legislative calendar brought on by the COVID-19 pandemic. AB 2830 (Wood) of 2020 would have established the HPD within OSHPD. AB 2830 was withdrawn for a hearing by the author in the Senate Health Committee. SB 17, among various provisions, requires health plans and insurers that report rate information through the existing large and small group rate review process to also report specified information related to prescription drug pricing to the DMHC and CDI; requires drug manufacturers to notify specified purchasers, in writing at least 90 days prior to the planned effective date, if it is increasing the wholesale acquisition cost of a prescription drug by specified amounts; and, requires drug manufacturers to provide specified information to OSHPD related to the drug's price.

REGISTERED SUPPORT / OPPOSITION:

Support

Alliance of Californians for Community Empowerment (ACCE) Action
Blue Shield of California
California Immigrant Policy Center
California Labor Federation
California Pan - Ethnic Health Network
California Physicians Alliance
California Public Interest Research Group
California Rural Legal Assistance Foundation, INC.
Children Now
Courage California
Desert AIDS Project
Health Access California
Justice in Aging
National Association of Social Workers, California Chapter
National Council of Jewish Women Los Angeles
National Multiple Sclerosis Society, MS-CAN
Purchaser Business Group on Health
Small Business Majority
Western Center on Law & Poverty, INC.

Opposition

None on file.

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