Assembly Budget Subcommittee #1
February 7, 2021, Addendum to Agenda
Issue #2 – Office of Health Care Affordability (OHCA)

Analysis of Proposed OHCA Trailer Bill

Section 1

- States legislative intent to ensure that enrollees and subscribers of Knox-Keene health care services plans benefit from reductions in the rate of growth in health care costs as a result of the OHCA.
- Requires health care service plans, in submitting rates for review, to demonstrate the impact of any changes in the rate of growth in health care costs resulting from the health care cost targets.
- Requires the director, in determining whether a rate is unreasonable or not justified, to consider the impact on changes in health care costs as a result of the health care cost targets.

Section 2

Article 1 – General Provisions and Definitions
Names this chapter: the "California Health Care Quality and Affordability Act."

Includes the following definitions:

- "***Exempted provider***" means:
  - A provider that meets standards established by the board for exemption from the (i) statewide health care target, or (ii) specific targets set for health care sectors, including the fully integrated delivery system sector, and geographic region, and for an individual health care entity. The factors used in setting standards for exemption may include, but are not limited to, annual gross and net revenues, patient volume, and high cost outlier in a given service or geographic region. In determining whether a provider is an exempted provider, the board shall also consider any affiliates, subsidiaries, or other entities that control, govern, or are financially responsible for the provider or that are subject to the control, governance, or financial control of the provider.

  - A physician practice that does not meet the definition in subdivision (q), which defines "physician organization," is an exempted provider.

- "***Physician organization***" includes any of the following:
  - An organization described in paragraph (2) of subdivision (g) of Section 1375.4.
  - A risk-bearing organization, as defined in Section 1375.4.
  - An independent practice association that negotiates contracts with one or more payers on behalf of a group of independent providers.
  - A medical foundation exempt from licensure pursuant to subdivision (l) of Section 1206.
  - Any of the following entities that employs or contracts with, or has a similar arrangement with, a substantial number of physicians and surgeons to provide, deliver, furnish, or otherwise arrange for health care services, except for risk-bearing organizations and independent practice organizations:
    - ✓ A medical group practice, including a professional medical corporation, as defined in Section 2406 of the Business and Professions Code.
    - ✓ A lawfully organized group of physicians and surgeons that delivers, furnishes, or otherwise arranges for health care services in any organizational form consistent with state law, including, but not limited to, a medical partnership or professional medical corporation.

- "***Substantial number of physicians and surgeons***" means the following:
  - Sixty or more physicians for entities comprised of primary care physicians.
  - Fifty or more physicians for entities comprised of primary care and specialty physicians.
  - Forty or more physicians for entities comprised of specialty physicians.

- Includes additional definitions including, but not limited to, the following: Affordability for consumers, affordability for purchasers, fully integrated delivery system, health care cost target, net cost of health coverage, expenditures for covered benefits, and per capita total health care expenditures.

- Makes findings and declarations, and establishes legislative intent, related to the value of accessible, affordable, equitable high-quality, and universal health care for all Californians.

Article 2 – Office of Health Care Affordability

- Establishes the Office of Health Care Affordability (OHCA) within the Department of Health Care Access and Information (HCAI), and requires it to:
  - Increase cost transparency through public reporting of per capita total health care spending and factors contributing to health care cost growth;
  - Establish a statewide health care cost target for per capita total health care spending;

- Set health care cost targets by health care sector;
- Collect and analyze data from existing and emerging public and private data sources to track spending, set cost targets, approve performance improvement plans, and monitor impacts on workforce stability;
- Analyze cost and quality trends for drugs covered by pharmaceutical and medical benefits;
- Oversee the state's progress towards meeting the health care cost target;
- Promote, measure, and publicly report performance on quality and health equity through the adoption of a priority set of standard quality and equity measures for health care entities;
- Advance standards for promoting the adoption of alternative payment models, and for health care workforce stability and training (related to costs);
- Measure and promote sustained system-wide investments in primary care and behavioral health;
- Disseminate best practices;
- Address consolidation, market power, and other market failures through cost and market impact reviews of mergers, acquisitions, or corporate affiliations;
- Analyze trends in the price of health care technologies, and in the cost of labor;
- Conduct ongoing research and evaluation on payers and providers; and
- Adopt and promulgate regulations for implementing this chapter.

- Provides an exemption to the Public Contract Code for non-competitive bid contracting, and authorizes adoption of emergency regulations.

- Requires the OHCA to be responsive, and provide information, expertise, and technical assistance, to the Legislature.

Data Collection

- Requires the OHCA to collect data and other information it determines necessary from health care entities to carry out its functions, including using the Health Care Payments Data Program, to the greatest extent possible, to minimize reporting burdens for payers and providers.

- Authorizes the OHCA to enter into data sharing agreements with the Departments of Health Care Services, Managed Health Care, and Insurance, the Labor and Workforce Development Agency, the Business, Consumer Services, and Housing Agency, and other relevant state agencies.

- Requires the OHCA to obtain information about health care service plans and insurers from the Departments of Managed Health Care and Insurance. Requires

this information to include: information on premiums, cost sharing, and benefits; trend factors by benefit category, medical loss ratio for each health care service plan or health insurer; cost containment and quality improvement efforts; prescription drug costs; and information on health equity and quality. Requires the OHCA to comply with any confidentiality requirements of the data obtained.

- Authorizes the OHCA to obtain information from Covered California about its enrollees and to enter into a data sharing agreement with Covered California.

- Requires the OHCA to establish requirements for payers to submit data and information in order to:
  - Measure total and per capita health care expenditures;
  - Determine if health care entities met cost targets;
  - Identify the annual change in health care costs;
  - Approve and monitor the implementation of performance improvement plans; and
  - Assess performance on quality and equity measures.

- Requires payers to submit aggregate data on total health care expenditures for the 2019, 2020, and 2021 calendar years on or before July 1, 2023, for the purpose of publicly reporting the impact of COVID-19 on health care spending; enforcement shall not be implemented for this report.

- Requires payers to submit data on total health care expenditures for the 2022 and 2023 calendar years on or before December 31, 2024, for the purpose of the establishing baseline health care spending.

- Requires the OHCA to:
  - Require health care service plans, health insurers, hospitals, and physician organizations to report data and other information necessary for standard quality measures;
  - Require payers to submit data and other information to measure the adoption of alternative payment models and the percentage of total health care expenditures allocated to primary care and behavioral health care; and
  - Require providers to submit audited financial reports, except for providers that do not routinely prepare audited financial reports who will be required to submit a comprehensive financial statement instead.

- Authorizes the OHCA to collect specified types of data and make it accessible to the public.

- Requires the OHCA to prepare a report on baseline health care spending on or before June 1, 2025.

- Requires the OHCA to prepare and publish, by June 1, 2026, its first annual report on health care spending trends, including policy recommendations to control costs and improve quality performance and equity. Specifies all of the required components of the annual report.

- Requires the OHCA to:
  - Present the annual report to the board at a public meeting;
  - Call for public statements on findings of the annual report from payers, providers and experts;
  - Seek comments from purchasers, including consumer advocacy organizations and other entities;
  - Solicit and collect comments from the public;
  - Notify the relevant regulatory agency and the Attorney General if a health care entity is impacting health care workforce stability or quality jobs, lowering quality, or reducing access to, or equity of, care;
  - Submit the report to the Governor and Legislature;
  - Make the report available to the public on the OHCA website; and
  - Enforce the Bagley-Keene Open Meeting Act for purposes of public meetings.

- Establishes the Health Care Affordability Fund, in order to return moneys to consumers and purchasers.

Health Care Affordability Board

- Establishes this board with eight members as follows:
  - Four members appointed by the Governor and confirmed by the Senate;
  - One member appointed by the Senate Committee on Rules;
  - One member appointed by the Speaker of the Assembly
  - The Secretary of Health and Human Services, or their designee; and
  - The CalPERS Chief Health Director or their deputy (non-voting member).

- Requires that all board members have demonstrated and acknowledged expertise in at least one of several specified issue/policy areas.

- Requires the board consist of a majority of members that do not receive financial compensation from providers or payers that are subject to the cost targets or cost and market impact reviews, or from exempted providers.

- Requires that board members receive a per diem.

- Requires the board to meet at least quarterly, or at the call of the chair, and that the board shall be subject to the Bagley-Keene Open Meeting Act.

- Requires the board to establish:
  - A statewide health care cost target;
  - The definitions of health care sectors and geographic regions and specific targets by health care sector; and
  - The standards for exemption from cost targets or submitting data directly to the OHCA.

- Requires the board to approve the:
  - Methodology for setting cost targets;
  - Scope and range for administrative penalties and the justification for assessing penalties;
  - Benchmarks for primary care and behavioral health spending;
  - Statewide goals for the adoption of alternative payment models; and
  - Standards to advance the stability of the health workforce.

- Requires the HCAI director to present specified information to the board for discussion.

Article 3 – Health Care Cost Targets

- Requires the board to establish: 1) a statewide health care cost target; and 2) specific targets for each health care sector, including a fully integrated delivery system sector and geographic region, and for an individual health care entity as appropriate.

- Authorizes the board to adjust cost targets by health care sector when warranted to account for the baseline costs in comparison to other cost targets.

- Requires the cost targets to meet specified requirements, related to predictability in health care expenditures, economic indicators, population-based measures, annual or multi-year targets, improved affordability for consumers and purchasers of health care, and others.

- Requires the HCAI director, in consultation with the board, to:
  - Develop a methodology to set health care cost targets, and to make the methodology available and transparent to the public. Requires the methodology to be developed based on various specified: conditions, data sources, historical trends, labor costs, high-cost outliers, services for populations with higher health care risks, and varying geographic labor costs.
  - Establish risk adjustment methodologies for the reporting of data on health care expenditures, and to make these methodologies available to the public.
  - Establish equity adjustment methodologies to take into account social determinants of health and other factors related to health equity, to the extent data is available and methodology has been developed and validated.

- Requires the HCAI director to:
  - Consult with the Departments of Managed Health Care and Insurance to ensure any targets for payers consider actuarial soundness and rate review requirements imposed by those departments.
  - Direct the public reporting of performance on the health care cost targets, which may include analysis of changes in total health care expenditures on an aggregate and per capita basis statewide, by geographic region, by insurance market, by payers and providers, and by impact on consumers and purchasers of health care.
  - Direct the analysis and public reporting of contributions of health care entities to cost growth in the state.

- Requires the board to establish a statewide health care cost target beginning with the 2025 calendar year and for each calendar year thereafter. The 2025 baseline target shall be a reporting year only and shall not be subject to enforcement. The targets established for the 2026 calendar year, and each calendar year thereafter, shall be enforced for compliance.

- *On or before 2027:*
  Requires the board to define health care sectors and geographic regions, considering factors such as delivery system characteristics, including a fully integrated delivery system sector or sectors.

- *No later than the 2028 calendar year:*
  Requires the board to set specific targets by health care sector, including the fully integrated delivery system sector and geographic region, and for any individual health care entity, as appropriate.

- Requires the board to adopt recommendations at a public meeting for proposed targets on or before April 1 of the year prior to the applicable target year.

- Requires the board to adopt final targets on or before June 30th of the year prior to the applicable calendar year, and if they have not met this deadline, must stay in session without per diem until targets are adopted.

Enforcement

- Requires the HCAI director to enforce the cost targets in a manner that: ensures compliance with targets; allows each health care entity opportunities for remediation; and ensures health care entities do not implement performance improvement plans in ways that are likely to erode access, quality, equity, or workforce stability.

- Authorizes the HCAI director to take the following progressive enforcement actions: 1) provide technical assistance; 2) require or compel public testimony by the health care entity regarding its failure to comply with the target; and 3) require submission and implementation of performance improvement plans for board input and approval; and 4) assess penalties.

- Requires the OHCA to monitor the health care entity for compliance with the performance improvement plan. Prohibits the office from approving a performance improvement plan that proposes to meet cost targets in ways that are likely to erode access, quality, equity or workforce stability.

- Authorizes the director, if, after the implementation of one or more performance improvement plans, the health care entity is repeatedly noncompliant with the performance improvement plan and exceeds the cost target, to assess escalating administrative penalties that exceed the prior penalties.

- Requires the Board to approve the range of penalties and the factors to determine the penalty amount.

- Authorizes the OHCA to establish requirements for health care entities to file for a waiver of enforcement actions due to reasonable factors outside the entity's control, such as changes in state or federal law or anticipated costs for investments and initiatives (e.g., innovation and infrastructure) to minimize future costly care, or under extraordinary circumstances, such as an "act of God" or catastrophic event.

Article 4 – Quality and Equity Performance

- Requires the OHCA to adopt a single set of standard measures for assessing health care quality and equity for health care service plans, health insurers, hospitals, and physician organizations. Requires that performance on quality and equity measures be included in the required annual report.

- Requires that the standard quality and equity measures:
  - Recognize clinical quality, patient experience, patient safety and utilization;
  - Reflect the diversity of California in terms of race, ethnicity, sex, age, language, sexual orientation, gender identity, and disability status;
  - Consider available means for reliable measurement of disparities in health care;
  - Reduce administrative burden by selecting measures that simplify reporting; and
  - Consider differences among health care entities such as plan or network design, provider payer mix, or other differences.

Article 5 – Alternative Payment Models

- Requires the OHCA to promote the shift from payments based on fee-for-service to those rewarding equitable high-quality and cost-efficient care.

- Requires the OHCA to convene payers and organize an alternative payment model working group, set statewide goals for the adoption of alternative payment models, and measure the state's progress toward those goals.

- Requires the OHCA, with input from the working group, to set benchmarks that include, but are not limited to, increasing the percentage of total health care expenditures delivered through alternate payment models or the percentage of membership covered by an alternative payment model.

- Requires the OHCA to advance statewide goals for adoption of alternative payment models, and work with the working group to develop standards for alternative payment models that may be used during contracting between providers and payers.

- Requires the OHCA to adopt the standards for alternative payment models on or before July 1, 2024, and requires that the standards:
  - Focus on encouraging and facilitating multi-payer participation and alignment, improving affordability, efficiency, equity, and quality;

- Include minimum criteria for an alternative payment model, but also flexibility to allow for innovation;
- Address appropriate incentives to providers; and
- Attempt to reduce administrative burden.

Article 6 – Primary Care and Behavioral Health Investments

- Requires the OHCA to:
  - Measure and promote a sustained system-wide investment in primary care and behavioral health;
  - Measure the percentage of total health care expenditures allocated to primary care and behavioral health and set spending benchmarks, considering current and historic underfunding of primary care services.
  - Measure performance of health care entities with regard to these spending benchmarks;
  - Promote improved outcomes for primary care and behavioral health, via specified strategies; and
  - Include an analysis of primary care and behavioral health spending and growth, and relevant quality and equity performance measures, in the required annual report.

Article 7 – Health Care Workforce Stability

- States legislative intent that the OHCA:
  - Monitor the effects of cost targets on health care workforce stability, high-quality jobs, and training needs of health care workers in addition to adjustments to cost targets pertaining to nonsupervisory employee labor costs; and
  - Use a transparent process that allows for public input to monitor how health care entities achieve the cost targets, highlight best practices, and discourage practices harmful to workers and patients.

- Requires the OHCA to:
  - Monitor health care costs while promoting health care workforce stability, including the competitive wages and benefits of frontline health care workers, and the professional judgment of health professionals, acting within their scope of practice; and
  - Develop standards to advance the stability of the health care workforce, on or before July 2024, in consultation with the board and with input from organized labor representing health care workers and other entities and individuals with expertise in the health care workforce.

Article 8 – Health Care Market Trends

- Requires the OHCA 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, venture capital activity, profit margins, and other market failures on competition, prices, access, quality, and equity.
  - 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.
  - Prospectively analyze those transactions likely to have significant effects, seek input from the parties and the public, and report on the anticipated impacts to the health care market.
  - Conduct a cost and market impact review, (if the office finds that a material change noticed is likely to have a risk of a significant impact on market competitions, the state's ability to meet cost targets, or costs for purchasers and consumers), 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 OHCA determines to be in the public interest.
  - Conduct cost and market impact reviews on any health care entity, based on a determination by the director, at the discretion of the OHCA.

- Requires a health care entity to provide the OHCA with written notice of agreements or transactions that will occur on or after April 1, 2024, that do either of the following:
  - Sell, transfer, lease, exchange, option, encumber, convey, or otherwise dispose of a material amount of its assets to one or more entities.
  - Transfer control, responsibility, or governance of a material amount of the assets or operations of the health care entity to one or more entities.

Section 3

- States legislative intent that the insureds benefit from reductions in the rate of growth in health care costs as a result of the establishment of the OHCA.
- Requires health insurers, in submitting rates for review, to demonstrate the impact of any changes in the rate of growth in health care costs resulting from the cost targets.

- Requires the Insurance Commissioner, in determining whether a rate is unreasonable or not justified, to consider the impact on changes in health care costs as a result of the health care cost targets.

Section 4

- Finds and declares that Section 2 of this act limits the public's right of access to public meetings or writings of public officials and agencies, and makes findings to demonstrate the interest protected by this limitation as follows:

  "This act balances the need for a government agency to obtain proprietary business information and private health care data with the public interest in monitoring the cost, quality, equity, and accessibility of health care services."

Section 5

- States that the provisions of this measure are severable, such that if any provision of this measure is held invalid, that invalidity shall not affect other provisions of the measure.

Section 6

- States that no reimbursement is required by this act.