HEALTH AND SAFETY CODE - HSC

DIVISION 107. HEALTH CARE ACCESS AND INFORMATION [127000 - 130079] *(Heading of Division 107 amended by Stats. 2021, Ch. 143, Sec. 28.)*

PART 2. HEALTH POLICY AND PLANNING [127280 - 127697] *(Part 2 added by Stats. 1995, Ch. 415, Sec. 9.)*

CHAPTER 2.6. Health Care Affordability [127500 - 127507.6] *(Chapter 2.6 added by Stats. 2022, Ch. 47, Sec. 19.)*

ARTICLE 1. General Provisions and Definitions [127500 - 127500.5] *(Article 1 added by Stats. 2022, Ch. 47, Sec. 19.)*

127500. This chapter shall be known, and may be cited, as the California Health Care Quality and Affordability Act.

(Added by Stats. 2022, Ch. 47, Sec. 19. (SB 184) Effective June 30, 2022.)

127500.2. As used in this chapter, the following definitions apply:

(a) (1) “Administrative costs and profits” means the total sum of all expenses not included in the numerator of the medical loss ratio calculation under state or federal law, including, but not limited to, all of the following:

(A) All categories of administrative expenditures.

(B) Net additions to reserves.

(C) Rate dividends or rebates.

(D) Profits or losses.

(E) Taxes and fees.

(2) For purposes of this chapter, “administrative costs and profits” for a fully integrated delivery system means those associated with its nonprofit health care services plan.

(b) “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 for public and private health coverage.

(c) “Affordability for purchasers” means considering the cost to purchasers, including, but not limited to, health plans and health insurers, employers purchasing group coverage, and the state, for health coverage and shall 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.

(d) “Alternative payment model” means a state or nationally recognized payment approach that financially incentivizes high-quality and cost-efficient care.

(e) “Board” means the Health Care Affordability Board established by Section 127501.10.

(f) “Director” means the Director of the Department of Health Care Access and Information.

(g) (1) “Exempted provider” means a provider that meets standards established by the board for exemption from either of the following:

(A) The statewide health care target.

(B) Specific targets set for health care sectors, including fully integrated delivery systems, geographic regions, and for individual health care entities.

(2) 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 outliers in a given service or geographic region.

(3) 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.

(4) A physician practice that does not meet the definition in subdivision (p) is an exempted provider.

(h) “Fully integrated delivery system” means a system that includes a physician organization, health facility or health system, and a nonprofit health care service plan that provides health care services to enrollees in a specific geographic region of the state through an affiliate hospital system and an exclusive contract between the nonprofit health care service plan and a single physician organization in each geographic region to provide those medical services.

(i) “Geographic region” may either be the regions specified in Section 1385.01 or may be otherwise defined by the board.

(j) “Health care cost target” means the target percentage for the maximum annual increase in per capita total health care expenditures.

(k) “Health care entity” means a payer, provider, or a fully integrated delivery system.

(l) “Insurance market” means the public and private health insurance markets.

(m) “Line of business” means the different individual, small, and large group business lines, as defined in Section 1348.95 of this code and Section 10127.19 of the Insurance Code, as well as Medi-Cal, Medicare, Covered California, or self-insured public employee health plans.

(n) “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.

(o) “Payer” means private and public health care payers, including all of the following:

(1) A health care service plan or a specialized mental health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2) or a Medi-Cal managed care plan contracted with the State Department of Health Care Services to provide full scope benefits to a Medi-Cal enrollee pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) of, Part 3 of Division 9 of the Welfare and Institutions Code.

(2) A health insurer licensed to provide health insurance or specialized behavioral health-only policies, as defined in Section 106 of the Insurance Code.

(3) A publicly funded health care program, including, but not limited to, Medi-Cal and Medicare.

(4) A third-party administrator.

(5) Any other public or private entity, other than an individual, that pays for or arranges for the purchase of health care services on behalf of employees, dependents, or retirees.

(p) “Physician organization” includes any of the following:

(1) An organization described in paragraph (2) of subdivision (g) of Section 1375.4.

(2) A risk-bearing organization, as defined in Section 1375.4.

(3) A restricted health care service plan and limited health care service plan under subdivision (a) of Section 1300.49 of Title 28 of the California Code of Regulations. The inclusion of restricted health care service plans and limited health care service plans in the definition of “physician organization” does not narrow, abrogate, or otherwise alter the regulatory authority of the Department of Managed Health Care over these entities.

(4) A medical foundation exempt from licensure pursuant to subdivision (l) of Section 1206.

(5) A medical group practice, a professional medical corporation, a medical partnership, or any lawfully organized group of physicians and surgeons that provides, delivers, furnishes, or otherwise arranges for health care services and is comprised of 25 or more physicians.

(6) Notwithstanding paragraph (5), an organization of less than 25 physicians, but that is a high-cost outlier whose costs for the same services provided are substantially higher compared to the statewide average, as identified through data sources that include, but are not limited to, data from state and federal agencies, other relevant supplemental data, such as financial data on providers that is submitted to state agencies, or data reported to HCAI under the Health Care Payments Data Program,

established pursuant to Chapter 8.5 (commencing with Section 127671). The cost of delivering the same services in a geographic region shall be considered to the extent that cost substantially deviates from the statewide average and reflects higher costs in that region unrelated to the market dominance of providers in that region or unrelated to the ownership, management, or asset structure chosen by the organization.

(q) “Provider” means any of the following that delivers or furnishes health care services:

(1) A physician organization.

(2) A health facility, as defined in Section 1250, including a general acute care hospital.

(3) A clinic conducted, operated, or maintained as an outpatient department of a hospital, as described in subdivision (d) of Section 1206.

(4) A clinic described in subdivision (l) of Section 1206.

(5) A clinic described in subdivision (a) of Section 1204.

(6) A specialty clinic, as described in paragraphs (1) to (3), inclusive, of subdivision (b) of Section 1204.

(7) An ambulatory surgical center or accredited outpatient setting.

(8) A clinical laboratory licensed or registered with the State Department of Public Health under Chapter 3 (commencing with Section 1200) of the Business and Professions Code.

(9) An imaging facility that employs or contracts with persons that are subject to the Radiation Control Law (Chapter 8 (commencing with Section 114960) of Part 9 of Division 104), or the Radiologic Technologists Act (Article 5 (commencing with Section 106955) of Chapter 4 of Part 1, or Article 6 (commencing with Section 107150) of Chapter 4 of Part 1 of Division 104).

(r) “Purchaser” means an individual, organization, or business entity that purchases health care services, including, but not limited to, trust funds, trade associations, and private and public employers who provide health care benefits to their employees, members, and dependents.

(s) “Total health care expenditures” means all health care spending in the state by public and private sources, including all of the following:

(1) All claims-based payments and encounters for covered health care benefits.

(2) All non-claims-based payments for covered health care benefits, such as capitation, salary, global budget, other alternative payment methods, or supplemental provider payments pursuant to the Medi-Cal program.

(3) All cost sharing for covered health care benefits paid by residents of this state, including, but not limited to, copayments, coinsurance, and deductibles.

(4) Administrative costs and profits.

(5) Pharmacy rebates and any inpatient or outpatient prescription drug costs not otherwise included in this subdivision.

(Added by Stats. 2022, Ch. 47, Sec. 19. (SB 184) Effective June 30, 2022.)

127500.5. (a) The Legislature finds and declares all of the following:

(1) It is in the public interest that all Californians receive health care that is accessible, affordable, equitable, high-quality, and universal.

(2) While California has reduced the uninsured share of its population to a historic low of 7 percent through implementation of the federal Patient Protection and Affordable Care Act (PPACA: Public Law 111-148) and other state efforts, affordability has reached a crisis point as health care costs continue to grow.

(3) As costs rise, employers are increasingly shifting the cost of premiums and deductibles to employees, negatively impacting the potential for wage growth. Between 2010 and 2018, wages in the state kept pace with inflation by increasing by 19 percent. Meanwhile, families with job-based coverage experienced a 45 percent increase in premiums, or more than twice the rate of wage growth. During the same period, families experienced a 70 percent increase in PPO deductibles, or nearly four times the rate of wage growth. While health insurance premium increases for 2021 may be considered moderate due to lower utilization of preventive, routine, and nonemergency services as a result of the novel coronavirus (COVID-19) pandemic, this abatement in health care cost growth is expected to be temporary.

(4) Escalating health care costs are being driven primarily by high prices and the underlying factors or market conditions that drive prices, particularly in geographic areas and sectors where there is a lack of competition due to consolidation, market power, venture capital activity, the role of profit margins, and other market failures. Consolidation through acquisitions, mergers, or corporate affiliations is pervasive across the industry and involves health care service plans, health insurers, hospitals, physician organizations, pharmacy benefit managers, and other health care entities. Further, market consolidation occurs in various forms, including horizontal, vertical, and cross industry mergers, transitions from nonprofit to for-profit status or vice versa, and any combination involving for-profit and nonprofit entities, such as a nonprofit entity merging with, acquiring, or entering into a corporate affiliation with a for-profit entity or vice versa.

(5) Californians of color experience health disparities, including barriers to accessing care, receiving lower quality of care, lack of access to culturally and linguistically competent care, and experiencing worse health outcomes. Certain communities, including low-income, Black, Latino, Pacific Islander, and essential workers, have been disproportionately impacted by COVID-19 in terms of higher rates of infection, hospitalizations, and deaths. These negative health outcomes further highlight a public health imperative to reduce racial and ethnic disparities in health care.

(6) The COVID-19 pandemic has exposed vulnerabilities within the current system with regard to provider payments. Physician fee-for-service payment has increased over the past decade, while the use of population-based prepayment has decreased in the employer-sponsored coverage market. As Californians stayed home, the loss of fee-for-service (FFS) payment revenue for providers has downstream impacts on access to care and for health care workers' economic security. Beyond exposing providers to considerable financial instability, FFS payments may not be the most effective way to incentivize providers to deliver high-quality and cost-efficient care or offer the flexibility to make practice changes that enable improved access, care coordination, patient engagement, and quality.

(7) Primary care is foundational to an effective health care system and evidence supports that greater use of primary care has been associated with lower costs, higher patient satisfaction, reduced low birth weight, fewer hospitalizations and emergency department visits, and lower mortality, among other key outcomes. However, the United States as a whole spends a far lower share of health care expenditures on primary care and experiences worse outcomes in life expectancy and mortality than other countries.

(8) Behavioral health needs are common among Californians, with most who need it not receiving treatment. National research finds that persons with mental health or substance use disorders have approximately two to three times higher medical costs than those with no behavioral health diagnosis. This research also shows that total health care spending on mental health and substance use disorder services have remained relatively flat between 2012 and 2017. Models that integrate primary care and behavioral health services have been shown to improve access to effective behavioral health services that improve health outcomes, as well as deliver a return on investment by reducing downstream health care costs.

(9) Surveys show that people are delaying or going without care due to concerns about cost, or are getting care but struggling to pay the resulting bill. In California, one in four people report problems paying or being unable to pay their medical bills, with two-thirds cutting back on basic household items like food and clothing to pay those bills. Concerns about affordability of coverage and care are expected to be exacerbated during the economic recession related to the COVID-19 pandemic, particularly among lower-wage workers.

(10) High drug prices contribute significantly to health care costs. Prescription drugs account for nearly one-fifth of health care spending. The Centers for Medicare and Medicaid Services project that prescription drug spending will grow faster and outpace other categories of health care spending in the years to come. Cost-effectiveness analyses often find that drugs are priced in excess of the value they deliver to patients.

(11) The State of California has a substantial public interest in the price and cost of health care coverage. California is a major purchaser through the Public Employees' Retirement System, the State Department of Health Care Services, the Department of General Services, the Department of Corrections and Rehabilitation, and other entities acting on behalf of a state purchaser. The government also provides major tax expenditures through the tax exclusion of employer-sponsored coverage and tax deductibility of coverage purchased by individuals, as well as tax deductibility of excess health care costs for individuals and families.

(b) It is the intent of the Legislature to have a comprehensive view of health care spending, cost trends, and variation to inform actions to reduce the overall rate of growth in health care costs while maintaining quality of care, with the goal of improving affordability, access, and equity of health care for Californians.

(c) It is the intent of the Legislature to encourage policies, payments, and initiatives that improve the affordability, quality, equity, efficiency, access, and value of health care service delivery, with a particular focus on ensuring health equity and reducing disparities in care, access, and outcomes across California.

(d) It is the intent of the Legislature to recognize and consider the unique health care needs of people with disabilities and chronic illnesses and the associated challenges with access, affordability, equity, quality, and delivery of health care.

(e) It is the intent of the Legislature for the State of California to achieve more affordable health care and better outcomes by consistently measuring and promoting sustained systemwide investment in primary care and behavioral health.

(f) It is the intent of the Legislature to facilitate increased adoption of alternative payment models that reward high-quality and cost-efficient care, including strategies for shared savings and downside risk arrangements and population-based payments.

(g) It is the intent of the Legislature to promote the goal of health care affordability while recognizing the need to maintain and increase the supply of trained, culturally and linguistically competent health care workers, and to monitor the effects of cost containment efforts on health care workforce stability, high-quality health care jobs, and the training needs of health care workers. It is the intent of the Legislature that cost containment does not constrain the health care workforce that California needs, including the competitive wages and benefits of frontline health care workers.

(h) It is the intent of the Legislature that health care cost targets not be used to place a floor or ceiling on health care workforce compensation.

(i) It is the intent of the Legislature to increase transparency on mergers, acquisitions, and corporate affiliations involving health care service plans, health insurers, hospitals or hospital systems, physician organizations, pharmacy benefit managers, and other health care entities that may impact market competition and affordability for consumers and purchasers.

(j) It is the intent of the Legislature to analyze cost and quality trends in the pharmaceutical sector, study the impact of drug prices and pharmaceutical market failures on affordability, and inform policy interventions to improve competition and lower consumer costs.

(k) It is the intent of the Legislature in enacting this chapter to provide accountability to the State of California for the affordability and cost of health care in California.

(l) It is the intent of the Legislature in enacting this chapter that the setting of health care cost targets distinguish between health care entities that deliver cost-efficient, high quality care and those that deliver high-cost care without commensurate improvements in overall quality.

(m) It is the intent of the Legislature in enacting this chapter that enforcement actions to address growth in per capita total health care expenditures are implemented in a progressive manner, such that health care entities are assisted to come into compliance with cost targets, including through technical assistance and performance improvement plans, before assessing administrative penalties unless there are egregious violations as specified in Section 127502.5.

(n) To avoid duplication of efforts and to avoid inconsistency between federal and state laws, it is the intent of the Legislature that collaboration occur between relevant regulatory agencies regarding whether a health care entity is in compliance or noncompliance with the cost targets.

(o) It is the intent of the Legislature, therefore, to establish a single entity within state government charged with doing all of the following:

(1) Developing a comprehensive strategy for cost containment in California, including measuring progress towards reducing the rate of growth in per capita total health care spending and ultimately lowering consumer spending on premiums and out-of-pocket costs, while maintaining quality, access, and equity of care, as well as promoting workforce stability and maintaining high-quality health care jobs.

(2) Addressing cost increases in excess of health care cost targets through public transparency, opportunities for remediation, and other progressive enforcement actions to achieve cost targets that optimize value in health care spending.

(3) Referring transactions that may reduce market competition or increase costs to the Attorney General for further review.

(Added by Stats. 2022, Ch. 47, Sec. 19. (SB 184) Effective June 30, 2022.)