AB-1474 Health care cost targets. (2025-2026)

Date Published: 03/28/2025 09:00 PM

AMENDED IN ASSEMBLY MARCH 28, 2025

CALIFORNIA LEGISLATURE— 2025–2026 REGULAR SESSION

ASSEMBLY BILL NO. 1474

Introduced by Assembly Member Patterson

February 21, 2025

~~An act to amend Section 123505 of the Health and Safety Code, relating to public health.~~ *An act to amend Section 127502 of the Health and Safety Code, relating to health care.*

LEGISLATIVE COUNSEL'S DIGEST

AB 1474, as amended, Patterson. ~~Community-based perinatal care.~~ *Health care cost targets.*

Existing law, the California Health Care Quality and Affordability Act, establishes within the Department of Health Care Access and Information, the Office of Health Care Affordability to analyze the health care market for cost trends and drivers of spending, develop data-informed policies for lowering health care costs for consumers and purchasers, set and enforce cost targets, and create a state strategy for controlling the cost of health care and ensuring affordability for consumers and purchasers.

Existing law requires the board to establish statewide health care cost targets for health care entities that meet specified requirements, including promoting the goal of improved affordability for consumers and purchasers of health care, while maintaining quality and equitable care. Existing law also requires the office to develop a methodology, for approval by the board, to set health care costs. Existing law requires the methodology to review historical trends and projects and requires the methodology to allow the board to adjust target costs downward when warranted, among other things.

This bill would require the cost targets to be adjusted for a provider or fully integrated delivery system, as appropriate, upon a showing that prescription drug costs are projected to grow faster than the rate of any applicable cost targets. The bill would require the methodology to require the board to adjust cost targets for a provider or fully integrated delivery system, as appropriate, to account for increased expenditures related to prescriptions drugs.

~~Existing law establishes the State Department of Public Health and sets forth its powers and duties, including, but not limited to, implementation and administration of a community-based system of comprehensive perinatal care for eligible women and infants. Existing law states the goals of the community-based comprehensive perinatal health care system as decreasing and maintaining the decreased level of perinatal, maternal, and infant mortality and morbidity and supporting methods of providing comprehensive prenatal care that prevent prematurity and the incidence of low birth weight.~~

~~This bill would make technical, nonsubstantive changes to those goals.~~
Vote: majority Appropriation: no Fiscal Committee: ~~no~~*yes* Local Program: no

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. *Section 127502 of the Health and Safety Code is amended to read:*

127502. (a) The board shall establish a statewide health care cost target.

(b) (1) The board shall establish specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate. The board shall define health care sectors, which may include geographic regions and individual health care entities, as appropriate, except for fully integrated delivery systems, and the office shall promulgate regulations accordingly.

(2) The board may adjust cost targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate, when warranted to account for the baseline costs in comparison to other health care entities in the health care sector and geographic region.

(3) The setting of different targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate, shall be informed by historical cost data and other relevant supplemental data, such as financial data on health care entities submitted to state agencies and the Health Care Payments Data Program, as well as consideration of access, quality, equity, and health care workforce stability and quality jobs pursuant to Section 127506.

(c) The health care cost targets shall meet all of the following requirements:

(1) Promote a predictable and sustainable rate of change in per capita total health care expenditures.

(2) (A) Be based on a target percentage, with consideration of economic indicators or population-based measures, and be developed based on a methodology that is available and transparent to the public.

(B) Economic indicators may include established measures reflecting the broader economy, the labor markets, and consumer cost trends.

(C) Population-based measures may include changes in the state's demographic factors that may influence demand for health care services, such as aging.

(3) Be set for each calendar year, with consideration of multiyear targets to provide health care entities with consistency, be updated periodically, and shall consider relevant adjustment factors.

(4) Be developed, applied, and enforced.

(5) Promote the goal of improved affordability for consumers and purchasers of health care, while maintaining quality and equitable care, including consideration of the impact on persons with disabilities and chronic illness.

(6) Promote the stability of the health care workforce, including the development of the future workforce, such as graduate medical education teaching, training, apprenticeships, and research.

(7) Be adjusted for a provider or fully integrated delivery system's cost target, as ~~appropriate~~ *appropriate,* upon a showing that nonsupervisory employee organized labor costs are projected to grow faster than the rate of any applicable cost targets.

(8) Be adjusted for a provider or fully integrated delivery system's cost target, as appropriate, upon a showing that prescription drug costs are projected to grow faster than the rate of any applicable cost targets.

(d) (1) Consistent with paragraph (1) of subdivision (b) of Section 127501.11, the office shall develop a methodology, for approval by the board, to set health care cost targets. The methodology shall be available and transparent to the public.

(2) The methodology shall review historical trends and projections for economic indicators and population-based measures.

(3) The methodology shall review historical trends in costs for Medi-Cal, Medicare, and commercial health care coverage. The methodology shall provide differential treatment of the 2020 and 2021 calendar years due to the impacts of COVID-19 on health care spending and health care entities.

(4) The methodology shall review potential factors to adjust future cost targets, including, but not limited to, the health care employment cost index, labor costs, the consumer price index for urban wage earners and clerical workers, impacts due to known emerging diseases, trends in the price of health care technologies, provider payer mix, state or local mandates such as

required capital improvement projects, and any relevant state and federal policy changes impacting covered benefits, provider reimbursement, and costs.

(5) (A) With respect to Medi-Cal, the methodology shall consider provision of nonfederal share, determined to be appropriate by the Director of Health Care Services, associated with Medi-Cal payments, such as expenditures by providers or provider-affiliated entities that serve as the nonfederal share associated with Medi-Cal reimbursement.

(B) The methodology may also consider all of the following:

(i) Supplemental payments to qualifying providers who provide services to Medi-Cal and underinsured patients.

(ii) Provisions of nonfederal share or reimbursement of state costs not associated with specific Medi-Cal reimbursement, but that supports the Medi-Cal program, and any other reimbursements and fees assessed by the State Department of Health Care Services, as determined appropriate by the Director of Health Care Services.

(iii) Health care-related taxes or fees that, in whole or in part, provide the nonfederal share associated with Medi-Cal payments or support the Medi-Cal program, as determined appropriate by the Director of Health Care Services.

(C) The methodology shall allow the board, to the extent necessary for the Medi-Cal program to comply with federal requirements to help ensure that full federal financial participation is available and not otherwise jeopardized related to services, programs, benefits, and contracts that involve funds disbursed by the State Department of Health Care Services, including but not limited to funds authorized pursuant to Title XIX (42 U. S.C. Sec. 1396 et seq.) of the Social Security Act or Title XXI of the Social Security Act (42 U.S.C. Sec. 1397aa et seq.), to adjust any targets, when warranted, as they pertain to health care entities in the Medi-Cal program, upon the request of the Director of Health Care Services.

(6) (A) The methodology shall allow the board to adjust cost targets downward, when warranted, for health care entities that deliver high-cost care that is not commensurate with improvements in quality, and upward, when warranted, for health care entities that deliver low cost, high quality care.

(B) Data sources on cost and quality performance of health care entities may include, but are not limited to, all of the following:

(i) Cost and quality performance data reported by or sourced from recognized quality improvement and transparency initiatives.

(ii) Any other relevant supplemental data, such as financial data on health care entities, submitted to state agencies, and data on costs, payments, and quality from the Health Care Payments Data Program established pursuant to Chapter 8.5 (commencing with Section 127671).

(iii) Any relevant federal, state, or local data.

(7) The methodology shall require the board to adjust cost targets for a provider or a fully integrated delivery system as ~~appropriate~~ *appropriate,* to account for actual or projected nonsupervisory employee organized labor costs, including increased expenditures related to compensation. For an adjustment to be effectuated, the provider, the fully integrated delivery system, or other associated party shall submit a request with supporting documentation in a format prescribed by the office. To validate the basis for the requested adjustment, the office may request or accept further information, such as any single labor agreement that is final and reflects the actual or projected increased nonsupervisory employee organized labor costs. The office may audit the submitted data and supporting information as necessary.

(8) The methodology shall require the board to adjust cost targets for a provider or a fully integrated delivery system as appropriate, to account for increased expenditures related to prescription drugs.

(e) The methodology for setting a sector target for an individual health care entity shall be developed taking into account the following:

(1) Allow for the setting of cost targets based on the entity's status as a high-cost outlier.

(2) Allow for the setting of cost targets that encourage an individual health care entity to serve populations with greater health care risks by incorporating all of the following:

(A) A risk factor adjustment reflecting the health status of the entity's patient mix, consistent with risk adjustment methodology developed under subdivision (f).

(B) An equity adjustment accounting for the social determinants of health and other factors related to health equity for the entity's patient mix, consistent with subdivision (g).

(C) A geographic cost adjustment reflecting the relative cost of doing business, including labor costs in the communities the entity operates.

(f) (1) In consultation with the board, the office shall establish risk adjustment methodologies for the reporting of data on total health care expenditures and may rely on existing risk adjustment methodologies. The methodology shall be available and transparent to the public.

(2) To select appropriate risk adjustment methodologies or inform the way any adjustments are applied to unadjusted data to account for the underlying health status of the population, the office may convene technical committees, as necessary.

(3) The risk adjustment methodologies selected or used to inform any adjustments shall take into account the impact of perverse incentives that may inflate the measurement of population risk, such as upcoding. The office may audit submitted data and make periodic adjustments to address those issues as necessary.

(g) In consultation with the board, the office shall 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.

(h) (1) Targets set for payers shall also include targets on administrative costs and profits to deter growth in administrative costs and profits.

(2) The targets established for a payer's administrative costs and profits under this subdivision may be subject to annual adjustment, but shall not increase to the extent the costs for the medical care portion of the medical loss ratio exceed a target.

(3) The office shall consult with the Department of Managed Health Care, the State Department of Health Care Services, and the Department of Insurance to ensure any targets for payers established by the office consider actuarial soundness and rate review requirements imposed by or upon those departments.

(i) (1) Until the board approves sector targets for fully integrated delivery systems, fully integrated delivery systems shall comply with the statewide cost target.

(2) Targets set for fully integrated delivery systems shall include all health care services, costs, and lines of business managed by that system in each separately administered geographic service area of the state. The system shall provide sufficient data and information, comparable to other unintegrated payers and providers, including patient risk mix, to the office to enable analysis and public reporting of performance, including by sector, insurance market, line of business, and separately administered geographic service area.

(3) Targets for fully integrated delivery systems shall include targets on payer administrative costs and profits.

(4) After the board approves sector targets for fully integrated delivery systems, a fully integrated delivery system shall be subject to a target for each of its geographic service areas in which a single medical group is responsible for providing, or arranging for the provision of, all professional services to the payer's enrollees.

(j) The office shall 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 for all of the following:

(1) Statewide.

(2) By geographic region.

(3) By insurance market and line of business, including for each payer.

(4) For health care entities, both unadjusted and using a risk adjustment methodology against the covered lives or patient populations, as applicable, for which they serve.

(5) For impact on affordability for consumers and purchasers of health care.

(k) The office shall direct the analysis and public reporting of contributions of health care entities to cost growth in the state using data that includes, but is not limited to, data submitted to the office, data from state and federal agencies, other relevant supplemental data, such as financial data on health care entities, that is submitted to state agencies, and the Health Care Payments Data Program, established pursuant to Chapter 8.5 (commencing with Section 127671).

(l) (1) The board shall establish a statewide health care cost target for 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 pursuant to Section

127502.5. The targets established for the 2026 calendar year, and each calendar year thereafter, shall be enforced for compliance pursuant to Section 127502.5.

(2) (A) On or before October 1, 2027, the board shall define initial health care sectors, which may include geographic regions and individual health care entities, as appropriate, except fully integrated delivery systems, considering factors such as delivery system characteristics. Sectors may be further defined over time.

(B) Not later than June 1, 2028, the board shall establish specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate, in accordance with this chapter.

(C) The development of sector targets shall be done in a manner that minimizes fragmentation and potential cost shifting and that encourages cooperation in meeting statewide and geographic region targets.

(D) Sector targets adopted under this subdivision shall specify which single sector target is applicable if a health care entity falls within two or more sectors.

(m) (1) The board shall hold a public meeting to discuss the development and adoption of recommendations for statewide cost targets, or specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities. The board shall deliberate and consider input, including recommendations from the office, the advisory committee, and public comment. Cost targets and other decisions of the board consistent with this section shall not be adopted, enforced, revised, or updated until presented at a subsequent public meeting. The meetings shall be subject to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code) consistent with paragraph (2) of subdivision (e) of Section 127501.10.

(2) The office shall publish on its internet website its recommendations for proposed cost targets for the board's review and consideration. The board shall discuss recommendations at a public meeting for proposed targets on or before March 1 of the year prior to the applicable target year.

(3) The board shall receive and consider public comments for 45 days after the board meeting.

(4) The board shall adopt final targets on or before June 1, at a board meeting. The board shall remain in session, and members shall not receive per diem under Section 127501.10, until the board adopts all required cost targets for the following calendar year.

(n) The adoption of cost targets under this section is exempt from the requirements of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(o) For purposes of this section, "individual health care entity" does not include an exempted provider.

(p) (1) Statewide and sector-specific health care cost targets do not apply to exempted providers. Upon approval by the board, the office shall promulgate regulations defining who is an exempted provider.

(2) This section does not exempt claims and non-claims-based payments for exempted providers, and associated cost-sharing amounts paid by consumers, from inclusion in the calculation of total health care expenditures and per capita total health care expenditures that uses data submitted by payers.

~~SECTION 1.Section 123505 of the Health and Safety Code is amended to read:~~

~~123505.The goals of the community based comprehensive perinatal health care system are both of the following:~~

~~(a)Decreasing and maintaining the decreased level of perinatal, maternal, and infant mortality and morbidity in the state.~~

~~(b)Supporting methods of providing comprehensive prenatal care that prevent prematurity and the incidence of low birth weight infants.~~