AMENDED IN ASSEMBLY MAY 2, 2018

AMENDED IN ASSEMBLY APRIL 17, 2018

AMENDED IN ASSEMBLY APRIL 9, 2018

AMENDED IN ASSEMBLY MARCH 23, 2018

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 3087

Introduced by Assembly Member Kalra
(Coauthor: Assembly Member Mark Stone)

February 16, 2018

An act to add Title 23 (commencing with Section 100600) to the Government Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 3087, as amended, Kalra. California Health Care Cost, Quality, and Equity Commission.

Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), enacted various health care coverage market reforms that took effect January 1, 2014. PPACA required each state, by January 1, 2014, to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. PPACA defines a "qualified health plan" as a plan that, among other requirements, provides an essential health benefits package. Existing state law creates the California Health Benefit Exchange, also known as Covered California, to facilitate the purchase of qualified health plans by qualified individuals and qualified small employers.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.

This bill would create the California Health Care Cost, Quality, and Equity Commission, an independent state agency, to control in-state health care costs and set the amounts accepted as payment by health plans, hospitals, physicians, physician groups, and other health care providers, among other things. The bill would provide that funding for the commission would be provided from the Managed Care Fund and the Insurance Fund, subject to appropriation by the Legislature. The bill would provide that the commission would have 11 paid members, including the Secretary of California Health and Human Services or his or her designee, a CalPERS representative, and 9 members with specified experience appointed to staggered 6-year terms by the Governor, Senate Committee on Rules, and Speaker of the Assembly, as specified. The bill would require the commission to convene an advisory committee to meet at least quarterly with ~~15~~ *19* volunteer members, including, but not limited to, a representative of a licensed health facility and a representative of CalPERS.

This bill would provide the powers of the commission, including authorization to adopt regulations and employ necessary staff, and would require the commission to meet at least quarterly and prepare a written report annually, as specified. The bill would require the commission, beginning July 1, 2019, to annually determine the base amounts that health care entities, as defined, are required to accept as full payment for health care services, and would specify that the base amount for a health care provider shall be a percentage of Medicare rates not lower than 100% of Medicare rates. The bill would permit a health care service plan or health insurer to negotiate a contracted rate that is not based on Medicare rates. The bill would exempt noncontracting physicians and other noncontracting health professionals, as defined, from the base amounts until health care service plans and health insurers provide information on average contracted amounts to the commission and the commission sets a base amount for

noncontracting physicians and other noncontracting health professionals. The bill would require the commission, on or before July 1, 2019, to establish an appeal process to consider adjustments to the base amounts to be paid to health care ~~providers,~~ *entities,* and would require the commission to consider specified factors during an appeal. The bill would require the commission to adopt regulations to establish the Purchaser Participation Program on or before July 1, 2019, to allow the commission's executive director to award reasonable ~~fees to a person or~~ *fees, not to exceed $400,000 annually, to an* organization that represents purchasers' *or consumers'* interests and made a substantial contribution to a regulation, order, or decision, as specified. The bill would require the commission to obtain the information necessary to determine total health care expenditures and to set a global growth cap for total health care expenditures, as specified.

This bill would require the commission to estimate the cost savings to the General Fund from lower health care costs paid by public employers because of this bill, and require the Department of Finance to estimate the cost to increase reimbursement rates, as specified, and estimate how much of those costs could be paid using the estimated cost savings to the General Fund. The bill would express the intent of the Legislature to transfer that cost savings, upon appropriation, to programs that recruit and retain health professionals in underserved areas, as specified.

This bill would exempt a Medi-Cal managed health care plan or individuals receiving coverage through Medicare or another federal health program from the bill's provisions. The bill would prohibit a health care provider from billing or collecting an amount other than the applicable cost sharing from an individual, and would provide that an individual would not owe a health care provider an amount other than that applicable cost sharing.

This bill would require all information to be submitted electronically to the commission to facilitate public disclosure, but would provide that specified information be kept confidential.

Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Title 23 (commencing with Section 100600) is added to the Government Code, to read:

TITLE 23. CALIFORNIA HEALTH CARE COST, QUALITY, AND EQUITY COMMISSION

Chapter 1. The Commission

100600. The Legislature finds and declares the following:

(a) Overall health care spending in the United States far outpaces the rest of the developed world. According to the federal Centers for Medicare and Medicaid Services, health care spending in the United States was 18 percent of the gross domestic product in 2016. In countries that belong to the Organization for Economic Cooperation and Development (OECD), average health care spending was 9 percent of those countries' gross domestic product last year. Spending on public programs in other OECD countries is roughly comparable to the United States' spending, but spending on private health care coverage is much higher in the United States than in other OECD countries.

(b) The use of health care services and the quality of health care services, as well as life expectancy itself, are lower in the United States than in other developed countries. We pay more for less.

(c) The chief cause of high health care spending in the United States is high prices. According to the Health Care Cost Institute's 2016 Health Care Cost and Utilization Report, the utilization of health care services has declined in the United States since 2012, but prices for all services have increased. In California, premiums for employer-sponsored health insurance increased 234 percent from 2002 to 2016, and new data disclosed by health insurance companies to state agencies pursuant *to* Section 1385.045 of the Health and Safety Code and Section 10181.4 of the Insurance Code demonstrate that 83 percent of premium increases in the large group market in 2018 were due to price inflation.

(d) Health care spending in the United States varies significantly. According to a recent study of 2.7 billion commercial hospital claims, using data that covers 30 percent of all Americans with employer-sponsored insurance, overall health care spending varies by a factor of three across all markets in the United States, while hospital prices within individual markets for the same procedures can vary by a factor of two. Higher health care spending is not associated with greater quality of health care. Higher hospital prices are positively associated with indicators of market power; hospital prices in monopoly markets are 15.3 percent higher than those in markets with four or more hospitals.

(e) It is the intent of the Legislature to establish an independent agency to regulate the cost of health care by regulating health care prices for health plans, hospitals, physicians, physician groups, and other health care cost drivers, while ensuring fair reimbursement rates for plans and providers, improving the quality of care received by Californians, and reducing health disparities among Californians.

(f) It is the intent of the Legislature to control unreasonable health care costs so that California is able to achieve a sustainable health care system with more equitable access to quality health care.

(g) It is the intent of the Legislature to ensure relief to individual health care consumers from the rising costs of premiums and out-of-pocket costs. It is also the intent of the Legislature to provide relief from rising health coverage costs to employers, including government agencies purchasing coverage on behalf of their employees.

(h) California has a substantial public interest in the price and cost of health care services and coverage in the commercial market. California is a major purchaser of employer coverage through the California Public Employees' Retirement System (CalPERS), 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. As of January 2018, the unmet liability for retiree health benefits exceeded the liability for retirement benefits for state employees. California also provides major tax expenditures through the tax exclusion of employer-sponsored coverage, tax deductibility of coverage purchased by individuals, tax deductibility of excess

health care costs for individuals and families, and the tax exclusion of the income earned by certain qualifying health care plans and providers.

100601. (a) There is in state government the California Health Care Cost, Quality, and Equity Commission, a state agency that shall be an independent public entity that is not affiliated with an agency or department. The commission shall consist of 11 members who are residents of California. Of the members of the commission, three shall be appointed by the Governor, three shall be appointed by the Senate Committee on Rules, and three shall be appointed by the Speaker of the Assembly. The Secretary of California Health and Human Services or his or her designee shall serve as a voting, ex officio member of the commission. A CalPERS representative shall be designated by the CalPERS Board of Administration to serve at the pleasure of *the* CalPERS Board of Administration as a voting, ex officio member of the commission.

(b) (1) A member of the commission, other than an ex officio member, shall be appointed for a term of six years. Appointments made by the Governor shall be subject to confirmation by the Senate. A member of the commission may continue to serve until the appointment and qualification of his or her successor. Vacancies shall be filled by appointment for the unexpired term. The commission shall elect a chairperson on an annual basis.

(2) Initial appointments shall be for staggered terms. The Governor shall appoint one member for two years, one member for four years, and one member for six years. The Senate Committee on Rules and the Speaker of the Assembly shall each appoint one member for one year and one member for three years.

(c) (1) Appointments to the commission shall be made as follows:

(A) One individual with demonstrated expertise in health care policy.

(B) One individual with demonstrated expertise in health care delivery.

(C) One health economist.

(D) One consumer advocate.

(E) One individual with demonstrated expertise in health care financing, including alternative payment methodologies.

(F) One representative of a labor union organization who serves as a trustee of a trust fund organized under state or federal law.

(G) One representative of an organization of employers with demonstrated expertise in health care purchasing.

(H) One physician.

(I) One individual with experience in hospital administration.

(2) An individual appointed to the commission may have more than one of the qualifications in paragraph (1). Each of the qualifications in paragraph (1) shall be represented by the members of the commission.

(d) Each member of the commission shall have the responsibility and duty to meet the requirements of this title and all applicable state and federal laws and regulations to serve the public interest of the public and private purchasers, payers, and providers of health care, and to protect the personal health information of health care consumers.

(e) The appointing authorities shall consider the expertise of the current members of the commission and make appointments to complement those members' expertise. The appointing authorities shall take into consideration the racial, ethnic, gender, and geographical diversity of the state so that the commission's composition reflects the communities of California.

(f) (1) A member of the commission or of the staff of the commission shall not be employed by, a consultant to, a member of the board of directors of, affiliated with, or otherwise a representative of a carrier or other insurer, an agent or broker, a pharmaceutical manufacturer, a health care provider, a health care facility, or a health clinic while serving on the commission or on the staff of the commission. A member of the commission or of the staff of the commission shall not be a member, a board member, or an employee of a trade association of carriers, pharmaceutical manufacturers, health care facilities, health clinics, or health care providers while serving on the commission or on the staff of the commission. A member of the commission or of the staff of the commission shall not be a health care provider unless he or she does not receive compensation for rendering services as a health care provider and does not have an ownership interest in a professional health care practice.

(2) A member of the commission shall not engage in ex parte communications with an individual or organization that may appeal to the commission.

(3) A member of the commission shall receive adequate compensation for his or her service on the commission. A member of the commission may receive a per diem and reimbursement for travel and other necessary expenses while engaged in the performance of official duties of the commission, as provided in Section 103 of the Business and Professions Code.

(4) Notwithstanding Section 100607, for purposes of this subdivision, "health care provider" means a person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Act or the Chiropractic Act.

(g) A member of the commission shall not make, participate in making, or attempt to use his or her official position to influence the making of a decision that he or she knows or has reason to know will have a reasonably foreseeable material financial effect, distinguishable from its effect on the public generally, on him or her, on a member of his or her immediate family, or on either of the following:

(1) A source of income, other than gifts and other than loans by a commercial lending institution in the regular course of business on terms available to the public without regard to official status, aggregating two hundred fifty dollars ($250) or more in value provided to, received by, or promised to the member within 12 months before the decision is made.

(2) A business entity in which the member is a director, officer, partner, trustee, or employee, or holds a position of management.

(h) The commission, a member of the commission, or an officer or employee of the commission shall not be liable in a private capacity for, or on account of, an act performed or obligation entered into in an official capacity, when done in good faith, without intent to defraud, and in connection with the administration, management, or conduct of this title or affairs related to this title.

(i) The commission shall hire an executive director to organize, administer, and manage the operations of the commission. The executive director shall be exempt from civil service and shall serve at the pleasure of the commission.

(j) The commission 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), except the commission

may hold closed sessions when considering matters related to litigation, personnel, and contracting.

100603. (a) The purpose of the commission is to:

(1) Set the amounts accepted as payment by health plans, hospitals, physicians, physician groups, and other health care providers.

(2) Determine methods for state government to reduce the cost of prescription drugs and medical devices paid for by private purchasers in the commercial market.

(3) Control in-state health care costs in a manner intended to improve health care quality, improve health outcomes, and reduce health disparities for all Californians.

(4) Reduce price discrimination by health care providers among health care purchasers and the variation in prices paid to providers by private purchasers in the commercial market.

(5) Ensure payments to health care providers *that* will permit them to provide medically necessary, effective, and efficient health care services in a manner that improves health outcomes, reduces health disparities, ~~ensure~~ *that will assure* there are an adequate number of providers to provide timely access to health care services for all Californians with commercial health coverage, and ~~ensure~~ *that will provide* a fair and reasonable return on investment to providers.

(6) Measure and reduce total health care expenditures per capita in the state.

(b) It is not the purpose of the commission to determine rates with respect to the Medi-Cal program or any other public health program. *It is the purpose of the commission to take into account the rates set by the Medi-Cal program in setting the amounts accepted as payment by health care providers, both for those health care providers who serve a disproportionate share of Medi-Cal beneficiaries and for those providers who provide highly specialized services.*

100605. (a) The commission shall convene an advisory committee composed of a diverse set of health care stakeholders with demonstrated expertise in private, commercial, or Medicare health care payments and financing, health care delivery, health care quality, health care workforce, population health, health equity, or a combination of these. Appointments shall be for a term of at least one year. The membership shall be as follows:

(1) A representative of a health care service plan licensed under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, an insurer offering a policy of health insurance as defined in subdivision (b) of Section 106 of the Insurance Code, or an association representing health care service plans.

(2) A representative of a licensed health facility as defined in Section 1250 of the Health and Safety Code.

(3) A representative of a clinic as defined in Section 1200 of the Health and Safety Code.

(4) A representative of an ambulatory surgery or other outpatient setting, as described in subdivision (a), (d), (e), (g), or (h) of Section 1248.1 of the Health and Safety Code or regulated by the Medical Board of California pursuant to Article 11.5 (commencing with Section 2215) of Chapter 5 of Division 2 of the Business and Professions Code.

(5) A representative of a laboratory, radiology, or imaging center.

(6) A physician and surgeon who is licensed in California to deliver or furnish health care services.

(7) A representative of a physician organization or medical group.

(8) A primary care physician.

(9) A behavioral health provider.

(10) A representative of health professionals who are solo practitioners and not members of a medical group or other organized group of health professionals.

(11) A representative of a Medicare critical access hospital or other small and rural hospital.

~~(8)~~

(12) A representative of an organization of the employees of hospital or medical group providers licensed or certified to deliver health care services.

~~(9)~~

(13) An expert in health information technology.

~~(10)~~

(14) Any other provider of a health care service that is licensed, certified, or otherwise regulated by the state.

~~(11)~~

(15) A representative of a self-insured or self-funded employer group health plan, multiemployer plan, or self-insured or self-funded joint labor-management trust that pays for health care services provided to beneficiaries.

~~(12)~~

(16) A representative of CalPERS.

~~(13)~~

(17) A representative of a large public sector purchaser of health care services.

~~(14)~~

(18) A representative of a large private sector purchaser of health care services.

~~(15)~~

(19) A representative of an organization representing health care consumers.

(b) The purpose and duties of the advisory committee shall be to advise the commission as follows:

(1) Provide recommendations to the commission regarding the establishment, implementation, and ongoing administration and evaluation of the commission.

(2) Advise the commission on topics requested by the commission.

(3) Suggest questions and agenda items to the commission for advisory committee consideration.

(c) (1) The advisory committee shall hold public meetings at least once every quarter, and shall solicit input on agendas and topics set by the commission. Meetings of the advisory committee are 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).

(2) A member of the advisory committee shall recuse himself or herself from any matter directly affecting his or her interests or the interests of the entity or organization represented by the member.

(d) Notwithstanding any other law, a member of the advisory committee shall not receive per diem, travel expense reimbursement, or other expense reimbursement related to his or her service on the advisory committee.

100607. For purposes of this title:

(a) "Adjusted amount" means the ~~maximum~~ amount of payment approved by the commission after the final decision on an appeal pursuant to this title that a health care entity may require from a purchaser as payment in full for health care services, in addition to applicable cost sharing.

(b) "Applicable cost sharing" means copayments, deductibles, coinsurance, and any other share of cost for services that is permitted consistent with state law and regulations or federal law, rules, and guidance. "Applicable cost sharing" does not include premiums or share of premiums.

(c) "Base amount" means the amount of payment for health care services as a percentage of Medicare rates that a health care entity may require from a purchaser as payment in full for health care services, in addition to any applicable cost sharing.

(d) "Commercial health coverage" means coverage that is paid for by individual consumers for their own benefit, employers for the benefit of employees and dependents, employee benefit plans for the benefit of plan participants and their dependents, or another individual or group health plan. "Commercial health coverage" is not Medicare, Medi-Cal, the Indian Health Service, the Federal Employees Health Benefit Program, or TRICARE.

(e) "Commission" means the California Health Care Cost, Quality, and Equity Commission as established in this title.

(f) "Health care entity" means the following:

(1) A health care service plan licensed under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code or an insurer offering a policy of health insurance as defined in subdivision (b) of Section 106 of the Insurance Code.

(2) A licensed health facility as defined in Section 1250 of the Health and Safety Code.

(3) A clinic as defined in Section 1200 of the Health and Safety Code.

(4) An ambulatory surgery or other outpatient setting, as described in subdivision (a), (d), (e), (g), or (h) of Section 1248.1 of the Health and Safety Code or regulated by the Medical Board of California pursuant to Article 11.5 (commencing with Section 2215) of Chapter 5 of Division 2 of the Business and Professions Code.

(5) A laboratory, radiology, or imaging center that is required to be licensed or certified by the state.

(6) A physician and surgeon or other professional who is licensed in California to deliver or furnish health care services and who is a member of a health profession in which some professionals bill independently for their services.

(7) A physician organization or medical group.

(8) Any other provider of a health care service that is licensed, certified, or otherwise regulated by the state and that bills separately or independently for that service.

(g) "Health care provider" means a health care entity as defined in paragraphs (2) to (8), inclusive, of subdivision (f).

(h) "Health care services" means covered benefits, including essential health benefits consistent with Section 1367.005 of the Health and Safety Code and any other covered benefits as provided in the evidence of coverage or plan documents provided by a health care service plan, health insurer, or self-insured plan.

(i) "Noncontracting physician" or "other noncontracting health professional" means a physician or *other* health professional who is not contracted with a state-licensed health care service plan or a health insurer licensed by the state.

(j) "Purchasers" means consumers who purchase health coverage as individuals and employers, plans, and trust funds that purchase health coverage or pay for health care benefits on the behalf of their employees, dependents, or plan members.

100608. (a) The commission shall do all of the following:

(1) Convene at least quarterly. The commission may meet more frequently as required to fulfill its purpose under this title.

(2) Annually prepare a written report on the implementation and performance of the commission during the preceding fiscal year, including, at a minimum, how funds were expended and the progress toward, and the achievement of, the requirements of this title.

(A) The report shall be publicly posted on the commission's Internet Web site.

(B) The report shall be annually transmitted to the Legislature and the Governor in compliance with Section 9795.

(3) Respond to requests for additional information from the Legislature, including providing testimony and commenting on proposed state legislation or policy issues.

(4) Maintain expenditures consistent with revenues.

(5) Exercise all powers reasonably necessary to carry out and comply with the duties, responsibilities, and requirements of this title.

(6) Consult with the advisory committee stakeholders relevant to carrying out the activities of this title.

(b) The commission may do the following:

(1) Enter into contracts.

(2) Sue and be sued.

(3) Receive and accept gifts, grants, or donations of moneys from an agency of the United States, an agency of the state, and a municipality, county, or other political subdivision of the state.

(4) Receive and accept gifts, grants, or donations from individuals, associations, private foundations, and corporations, in compliance with the conflict of interest provisions to be adopted by the commission at a public meeting.

(5) Adopt rules and regulations, as necessary. Until January 1, 2022, necessary rules and regulations may be adopted as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2). The adoption of these regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare.

(6) Share information with relevant state departments necessary for the administration of the commission.

(7) Employ necessary staff.

(A) The commission shall hire a chief fiscal officer, a chief operations officer, a chief technology and information officer, a general counsel, and other key executive positions, as determined by the commission, who shall be exempt from civil service.

(B) The commission shall set the salaries for the exempt positions described in paragraph (1) and in subdivision (i) of Section 100601 in amounts that are reasonably necessary to attract and retain individuals of superior qualifications. The salaries shall be published by the commission in the commission's annual budget. The commission's annual budget shall be posted on the Internet Web site of the commission. To determine the compensation for these positions, the commission shall cause to be conducted, through the use of independent outside advisors, salary surveys of both of the following:

(i) Other state and federal health care commissions that are most comparable to the commission.

(ii) Other relevant labor pools.

(C) The salaries established by the commission under subparagraph (B) shall not exceed the highest comparable salary for a position of that type, as determined by the surveys conducted pursuant to subparagraph (B).

(D) The Department of Human Resources shall review the methodology used in the surveys conducted pursuant to subparagraph (A).

(E) The positions described in paragraph (1) and subdivision (i) of Section 100601 shall not be subject to otherwise applicable provisions of the Government Code or the Public Contract Code and, solely for the purpose of determining the salaries for those positions, the commission shall not be considered a state agency or public entity.

(c) Notwithstanding any other law, the commission shall not be subject to licensure or regulation by the Department of Insurance or the Department of Managed Health Care.

100609. (a) This title shall not apply to a Medi-Cal managed health care service plan or an entity that enters into a contract with the State Department of Health Care Services 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.

(b) This title shall not apply to individuals receiving coverage through the Medicare program or any other federal program, including the Indian Health Service, TRICARE, the Federal Employees Health Benefit Program, or any other federal program providing health care services.

(c) Notwithstanding any other law, the amounts paid for services under this title shall not constitute a health care provider's uniform, published, prevailing, or customary charges and shall not be used for purposes of a payment limit under the federal Medicare Program, the Medi-Cal program, or any other federal or state-financed health care program.

(d) This title is not intended to act upon, govern, impose obligations upon, or otherwise regulate employee welfare benefit plans regulated by the Employee Retirement Income Security Act

of 1974. This title does not prohibit those plans from accessing the rates set by the commission for regulated health care entities.

(e) An employee welfare benefit plan regulated by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Sec. 1001 et seq.)(ERISA) may elect to pay the base and adjusted amounts set by the commission for a regulated health care provider. If an ERISA plan elects to pay amounts set by the commission, those amounts shall constitute contracted rates and regulated health care providers shall not charge in excess of those amounts.

100610. (a) On or before July 1, 2019, the commission shall adopt regulations to establish the Purchaser Participation Program, which shall allow for the executive director to award reasonable advocacy and witness fees to ~~a person or~~ *an* organization that demonstrates that the ~~person or~~ organization represents the interests of purchasers *or consumers* and has made a substantial contribution on behalf of purchasers to the adoption of a regulation or to an order or decision made by the director if the order or decision has the potential to impact a significant number of *purchasers or* consumers.

(b) The regulations adopted by the commission shall include specifications for eligibility of participation, rates of compensation, and procedures for seeking compensation. The regulations shall require that the ~~person or~~ organization demonstrate a record of advocacy on behalf of health care *purchasers or* consumers in administrative or legislative proceedings in order to determine whether the ~~person or~~ organization represents the interests of ~~purchasers.~~ *purchasers or consumers.*

(c) This section shall apply to ~~all~~ proceedings of the commission, including ~~individual rate cases.~~ *the following:*

(1) Determination of the base amounts pursuant to this title.

(2) Appeals pursuant to this title.

(3) Overall cost, quality, and equity goals.

(4) Other matters the commission may, by regulation, determine to be appropriate.

(d) The fees awarded pursuant to this section shall be considered costs and expenses pursuant to Section 100612 and shall be paid from the assessments made under that section.

(e) (1) The commission shall report the following information on or before March 1, 2020, and annually thereafter:

(A) The amount of reasonable advocacy and witness fees awarded each fiscal year.

(B) The ~~individuals or~~ organizations to ~~whom~~ *which* advocacy and witness fees were awarded pursuant to this section.

(C) The orders, decisions, and regulations pursuant to which the advocacy and witness fees were awarded.

(2) The report shall be publicly posted on the commission's Internet Web site.

(3) The report shall be annually transmitted to the appropriate policy and fiscal committees of the Legislature in compliance with Section 9795.

(f) The fees awarded by the commission pursuant to this section shall not exceed four hundred thousand dollars ($400,000) per year.

(g) This section shall remain in effect only until five years after the effective date of the regulations required by this section, and as of that date is repealed, unless a later enacted statute deletes or extends that date.

100612. (a) Funding for the actual and necessary expenses of the commission in implementing this title shall be provided, subject to appropriation by the Legislature, from transfers of moneys from the following funds:

(1) The Managed Care Fund.

(2) The Insurance Fund.

(b) The share of funding from the Managed Care Fund shall be based on the number of covered lives in the state that are covered under plans regulated by the Department of Managed Health Care, including covered lives under Medi-Cal managed care, as determined by the Department of Managed Health Care, in proportion to the total number of covered lives in the state.

(c) The share of funding from the Insurance Fund shall be based on the number of covered lives in the state that are covered under health insurance policies and benefit plans regulated by the Department of Insurance, including covered lives under Medicare supplement plans, as determined by the Department of Insurance, in proportion to the total number of covered lives in the state.

(d) The allocation of the share of funding from the funds described in subdivision (a) shall be determined annually during the budget process.

CHAPTER 2. POWERS OF THE COMMISSION

100620. (a) (1) Beginning July 1, 2019, and annually thereafter, the commission shall establish base amounts that health care entities shall accept as payment in full for health care services, in addition to applicable cost sharing. The base amount shall apply to a contract with a health care entity that was issued, amended, or renewed on or after the effective date of the base amount. The commission shall determine the effective date or dates of base amounts, which shall be no earlier than July 1, 2019.

(2) On or before July 1, 2019, the commission shall adopt regulations governing the annual determination of base amounts. In its determination of the base amounts, the commission shall allow the submission of written comments and testimony by health care entities and purchasers.

(3) The annual determination of base amounts shall be exempt from the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2).

(b) The commission shall annually determine the percentage of Medicare rates used to determine the base amount. For health care providers, the percentage determined by the commission shall not be lower than 100 percent of Medicare rates, and may exceed Medicare rates.

(1) For health care providers, base amounts shall be a percentage of the rate that Medicare reimburses for the same or similar services in the general geographic region in which the services were rendered, unless those services are provided on a contractual basis to a health care service plan or health insurer licensed by the state.

(2) For a health care service plan contract or a policy of health insurance, the base amount shall be a percentage of the capitated rate a health plan receives for Medicare Advantage for the county where an enrollee or insured resides, adjusted for all of the following:

(A) Age.

(B) Risk mix.

(C) Differences in cost sharing between the Medicare Advantage plan and the coverage offered by the health care service plan or health insurer.

(D) Other actuarial factors permissible under state and federal law.

(3) In determining the base amounts, the commission shall take into account all of the following:

(A) Evidence of the financial status of hospitals, other health care providers, and Medicare Advantage plans, as well as the compensation of physicians and other health professionals in California. As part of that determination, the commission shall consider whether or not the health care entity is receiving a fair return on investment and avoidance of confiscatory results.

(B) Changes in state or federal laws that result in a change in costs.

(C) Reasonable increases in labor costs, including salaries and benefits, and changes in collective bargaining agreements or prevailing wage.

(D) Reasonable increases in capital investments, including those associated with compliance with state or federal law.

(E) Changes in the delivery of care that require adjustments in rates, such as the development of new modalities of care or new systems of care.

(4) The commission may allow different percentages of Medicare rates to be used for different health care entities, including different percentages for Medicare Advantage than for the amounts paid to health care providers.

(5) A health care service plan or health insurer may negotiate contracted rates with contracting health *care* providers that are not based on the Medicare rates as provided in this section.

(6) For a health care service plan contract or a policy of health insurance, the base amount determined by the commission shall constitute the allowed premium.

(c) (1) The commission shall establish a process for developing base amounts for health care services not currently reimbursed by Medicare or Medicare Advantage.

(2) The commission shall establish a process for determining reimbursement rates for health care services infrequently reimbursed by Medicare or Medicare Advantage. This shall include, at a minimum, pediatrics, obstetrics, and gynecology.

(3) On an annual basis, the commission shall review Medi-Cal reimbursement, including both fee-for-service and managed care rates, in comparison to the base amounts allowed under this title. In reviewing the Medi-Cal managed care rates, the commission shall review information regarding the adequacy of networks and

timely access to care, as well as the rates paid by managed care plans to health professionals. To further the goals and purposes of this title, the commission shall consider Medi-Cal reimbursement in determining base amounts. In determining the base amounts for health care providers, the commission shall consider whether the base amounts should be adjusted to create an incentive for providers to participate in Medi-Cal.

(d) The commission shall determine whether or not to include or alter Medicare rating factors, such as Medicare disproportionate share hospital rates, graduate medical education, readmission penalties, and other added rates as Medicare may allow. Until the commission makes that determination, the base amount shall not include those factors.

(e) The commission shall review and adjust overall rates or specific rates to maintain the workforce necessary to deliver quality, equitable health care throughout the state, and may make adjustments to ensure access to *care for* underserved populations throughout the state.

(f) The commission shall review the base amounts annually to ensure that the amounts are sufficient to ensure all of the following:

(1) The financial solvency requirements under state law for each of the following:

(A) Health care service plans licensed under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.

(B) Insurers offering policies of health insurance as defined in subdivision (b) of Section 106 of the Insurance Code.

(C) Risk-bearing organizations as defined in Section 1375.4 of the Health and Safety Code.

(2) A fair return on investment for the health care entity.

(3) Avoidance of confiscatory results.

(4) Improvements in health outcomes.

(5) Improvements in health disparities and reductions in health system costs consistent with this title.

(6) Availability and accessibility of health care services, including compliance with state requirements regarding network adequacy, timely access, and language access.

(g) The commission shall separately consider the impact of the base amounts in underserved areas, including rural areas determined to be underserved in accordance with state and federal

requirements. To mitigate the impact of the base amounts on the availability and accessibility of health care services in underserved areas, the commission may adjust the base amounts for *health care entities providing* services ~~provided~~ in those areas.

(h) In determining base amounts, the commission may take into account the reliance of the category of hospital or health professional on reimbursement by the Medi-Cal program, including supplemental Medi-Cal rates, such as disproportionate share hospital payments, intergovernmental transfers, prospective payment system rates for clinics, reimbursement based on quality assurance fees, or other supplemental Medi-Cal rates that the provider receives.

(i) If the commission determines that the Medicare ~~reimbursement system has substantially changed and no longer serves the interests of Californians, then the commission may make recommendations to the Governor and the Legislature to ensure that the commission continues to fulfill its purpose.~~ *rates or rate methodology has changed substantially, then the commission shall consider that in determining the base amount.*

100621. (a) To develop appropriate base amounts for noncontracting physicians and other noncontracting health professionals, health care service plans and health insurers shall provide to the commission the average contracted amount for the same or similar services in the general geographic regions in which the services were rendered for the three calendar years before the effective date of this title. For purposes of this subdivision, "average contracted rate" means the average of the contracted commercial rates paid by the health care service plan, delegated health entity, or health insurer for the same or similar services in the geographic region.

(b) Until the data submitted pursuant to subdivision (a) is available to the commission, the commission shall not set a base amount for noncontracting physicians and other noncontracting health professionals.

(c) To determine the base amounts for noncontracting physicians and other noncontracting health professionals, the commission shall take into account the commercial contracted rates paid in the three prior calendar years.

(d) This section shall not apply to physicians and other health professionals contracting with health care service plans or health insurers.

(e) Until the commission determines the base amounts for noncontracting physicians and other noncontracting health professionals, a physician or health professional who does not contract with a health care service plan or health insurer shall not be subject to the base amount.

100622. (a) It is the intent of the Legislature to better align the financing of the Medi-Cal program, including both the fee-for-service program and Medi-Cal managed care, with Medicare rates.

(b) It is also the intent of the Legislature that savings to the General Fund from lower health care costs for public employers as a result of this title be directed, upon appropriation by the Legislature, to the Steven M. Thompson Physician Corps Loan Repayment Program, the Song-Brown Healthcare Workforce Training Programs, the Health Professions Education Fund, and other programs intended to recruit and retain health professionals in underserved areas.

(c) Beginning October 1, 2020, and on or before October 1 annually thereafter, the commission shall estimate the savings to the General Fund from lower health care costs paid by public employers, including the state and local governments, as a result of this title, and shall report the estimated savings to the Department of Finance and the Legislature.

(d) The Department of Finance shall provide an estimate of the cost to increase reimbursement rates for physicians and other health care providers to be comparable to Medicare, taking into account the differences in populations served. The Department of Finance shall include in its estimate an analysis of how much of the cost would be provided through federal financial participation and how much could be paid out of the estimated savings to the General Fund from lower health costs for public employers.

100623. If the commission determines that the Medicare reimbursement system has substantially changed and no longer serves the interests of Californians, then the commission may make recommendations to the Governor and the Legislature to ensure that the commission continues to fulfill its purpose.

100625. (a) On or before July 1, 2019, the commission shall establish an appeals process for the purpose of considering adjustments to the base amounts to be paid to health care ~~providers.~~ *entities.*

(b) The commission shall establish by regulation uniform written procedures for notice and the submission, receipt, processing, and consideration of appeals.

(c) The commission shall establish criteria, by regulation, for considering and making decisions on appeals to the base amount.

(d) Decisions on appeals shall be rendered within six months of the filing of an appeal. A filing shall not be considered complete until the entity that is appealing has produced the documentation reasonably required by the commission.

(e) A health care entity filing an appeal shall certify that it has a good faith basis for pursuing the appeal and shall identify the specific factor or factors enumerated in Section 100626 on which the appeal is based.

100626. (a) The commission shall consider an appeal of the base amounts, filed by a health care ~~entity,~~ *entity that is subject to the base amount*, based on the following:

(1) The overall financial condition of the health care entity.

(2) A fair return on investment by a health care entity.

(3) Avoidance of confiscatory results.

(4) Risks to the ongoing operation of the health care entity and its financial solvency, if financial solvency requirements are imposed by law.

(5) Justifiable differences in costs among health care entities, such as providing a service not available from other providers in the region, or the need for health care services in rural areas with a shortage of health professionals or medically underserved areas and populations.

(6) Factors that led to increased costs for the health care entity that can reasonably be considered to be unanticipated and out of the control of the entity. Those factors may include, but shall not be limited to:

(A) Natural disasters.

(B) Outbreaks of epidemics or infectious diseases.

(C) Unanticipated facility or equipment repairs purchases.

(D) Unanticipated increases in a share of low-income, Medi-Cal, or uninsured populations.

(E) Significant and unanticipated increases in pharmaceutical or medical device prices.

(7) Changes in state or federal laws that result in a change in costs.

(8) Reasonable increases in labor costs, including salaries and benefits, and changes in collective bargaining agreements, prevailing wage, or local law.

(9) Reasonable increases in capital investments, including those associated with compliance with state or federal law.

(10) Changes in the delivery of care that require adjustments in rates, such as the development of new modalities of care or new systems of care.

(b) (1) The base amount set by the commission to be paid to the health care entity shall stay in effect during the appeal process, subject to interim relief provisions.

(2) The commission shall have the power to grant interim relief based on fairness. The commission shall develop regulations governing interim relief. The commission shall establish uniform written procedures for the submission, processing, and consideration of an interim relief appeal by a health care entity. A decision on interim relief shall be granted within one month of the filing of an interim relief appeal. A health care entity shall certify in its interim relief appeal that the request is made on the basis that the challenged amount is arbitrary and capricious, or that the health care entity has experienced a bona fide emergency based on unanticipated costs or costs outside the control of the entity, including those in paragraph (6) of subdivision (a).

(c) (1) In accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2), the commission may delegate the conduct of a hearing to an administrative law judge, who shall issue a proposed decision with findings of fact and conclusions of law.

(2) The administrative law judge may hold evidentiary hearings and shall issue a proposed decision with findings of fact and conclusions of law, including a recommended adjusted amount, within four months of the filing of the appeal.

(3) Within 30 days of receipt of the proposed decision by the administrative law judge, the commission may approve, disapprove, or modify the decision, and shall issue a final decision with an adjusted amount for the appealing health care entity.

(d) A final determination by the commission shall be subject to judicial review pursuant to Section 1094.5 of the Code of Civil Procedure.

100627. (a) The commission shall have the power to obtain information that is necessary to its deliberations.

(b) The commission shall receive the following information from the following entities:

(1) Information regarding facilities, workforce, and prescription drug prices from the Office of Statewide Health Planning and Development.

(2) Information regarding rate review and other information relevant to timely access to care, adequacy of network, and medical surveys from the Department of Managed Health Care and the Department of Insurance.

(3) Information regarding licensed health professionals from the Department of Consumer Affairs, the Medical Board of California, and other health profession licensing boards.

(c) The commission shall establish protocols to receive information pursuant to subdivision (b).

(d) The commission may require a health care entity or entities to provide information to allow the commission to fulfill its obligations pursuant to this title.

100628. (a) Notwithstanding Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1, all information submitted pursuant to this title shall be made publicly available by the commission.

(b) Notwithstanding subdivision (a), records of the commission that reveal the following shall be confidential and exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1):

(1) The contracted rates between a health care service plan and a provider.

(2) The contracted rates between a health care service plan and a large group.

(3) Information provided to a large group purchaser pursuant to Section 1385.10 of the Health and Safety Code.

(c) The contracted rates between a health care service plan and a provider shall not be disclosed by a health care service plan to a large group purchaser that receives information pursuant to Section 1385.10 of the Health and Safety Code.

(d) All information submitted to the commission under this chapter shall be submitted electronically to facilitate review by the department and the public.

(e) (1) The commission shall, at a minimum, make the following information readily available to the public on its Internet Web site, in plain language and in a manner and format specified by the commission, except as provided in subdivision (b):

(A) Justifications for an appeal, consistent with Section 100626, including all supporting information and documentation.

(B) Information on pending appeals and final decisions on appeals.

(C) A plain language summary of the reasons for the determination regarding the appeal, consistent with Section 100626.

(D) Information on the base amounts determined by the commission, including the percentages and factors taken into account to determine the base amount, consistent with Section 100614.

(2) The information posted to the commission's Internet Web site pursuant to paragraph (1) shall be made public for 60 days before the hearing of an appeal.

100629. (a) An individual shall not owe a health care provider an amount other than the applicable cost sharing that is otherwise permitted by law.

(b) For a service subject to this title, a health care provider shall not bill or collect an amount from an individual other than the applicable cost sharing.

(c) If a service is not a covered benefit, the health care provider may bill the individual and may collect the base amount from that individual. If the commission has not determined the base amount for a particular service that is not a covered benefit, then the health care provider shall determine an appropriate amount for the service and may bill the individual as otherwise permitted by law.

(d) If an individual does not have health coverage, the individual shall not pay more than the base or adjusted amount determined pursuant to this title.

Chapter 3. Overall Cost, Quality, and Equity Goals

100640. (a) The commission shall obtain the information necessary to determine total health care expenditures and shall set

a global cap on the annual growth of total health care expenditures that does not exceed the annual growth of the gross state product.

(b) The commission shall use existing data sources to determine total health care expenditures to the extent publicly available. If appropriate data sources do not exist, the commission shall require sufficient data to be collected to allow it to measure the cost of health care, as well as impacts on quality, equity, and workforce adequacy.

(c) The commission shall identify the reasons why there has been a failure to achieve the global growth cap and may order corrective action in order to reduce expenditures to stay below the global growth cap.

(d) The commission shall report at least annually on the total health care expenditures and the global growth cap. The commission shall vote on that report at a regularly scheduled meeting of the commission.

(1) The report shall be publicly posted on the commission's Internet Web site.

(2) The report shall be annually transmitted to the Legislature and the Governor in compliance with Section 9795.

100641. In determining the global growth cap for total health care expenditures, the commission shall take into account the adequacy of funding for the Medi-Cal program, including both the fee-for-service program and the Medi-Cal managed care program. The commission shall consider the impact on quality and equity of the adequacy of funding the Medi-Cal program.

100642. (a) The commission shall review and consider increases in prescription drug prices, consistent with Chapter 9 (commencing with Section 127675) of Part 2 of Division 107 of the Health and Safety Code.

(b) The commission shall also review and consider the impact of prescription drug costs on premiums and cost sharing of health care service plans and health insurers, using the information made available through rate review under Article 6.2 (commencing with Section 1385.01) of Chapter 2.2 of Division 2 of the Health and Safety Code and Article 4.5 (commencing with Section 10181) of Chapter 1 of Part 2 of Division 2 of the Insurance Code.

(c) The commission shall consider whether or not value-based purchasing of prescription drugs would help to achieve the goals of this chapter.

(d) The commission shall evaluate whether or not the state has the authority to regulate or reduce high prescription drug prices charged to health care entities subject to this title.

100650. If a section, subdivision, sentence, clause, or phrase of this title, or the application thereof to a person or circumstances, is held invalid, the validity of the remainder of the title, or the application of that provision to other persons or circumstances, shall not be affected. The Legislature hereby declares that it would have passed this title, and each section, subdivision, sentence, clause, and phrase thereof, irrespective of the fact that one or more sections, subdivisions, sentences, clauses, or phrases, or the application thereof, to a person or circumstance, may be held invalid.

SEC. 2. The Legislature finds and declares that Section 1 of this act, which adds Section 100628 to the Government Code, imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

In order to protect proprietary information, it is necessary for that information to remain confidential.

O