

HEALTH AND SAFETY CODE, DIVISION 107.5 (§§ 130071 ET SEQ)

An act to add Division 107.5 to the Health and Safety Code, relating to health care costs and quality.

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

Section 1. Citation of Division

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

Section 2. Definitions

As used in this division, the following terms have the following meanings:

(a) "Affordability for consumers" means the cost relative to the amount that the consumer is able to pay or priced reasonably such that the consumer is able to pay for it. Affordability for consumers considers 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, inclusive of deductibles, copays, coinsurance, and other forms of cost-sharing.

(b) "Affordability for purchasers" means the cost relative to the amount the purchaser is able to pay or priced reasonably such that the purchaser is able to pay for it. Affordability for purchasers considers, but is not limited to, 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.

(c) "Alternative payment model" means a payment approach that rewards high quality and cost-efficient care.

(d) "Board" means the Health Care Affordability Advisory Board established by Section [5].

(e) "Director" means the director of the Office of Health Care Affordability.

(f) "Exempted provider" means a provider, as defined in paragraph (o), that meets standards established by the Office for exemption from sector specific cost targets and/or reporting directly to the Office. The factors used in setting standards for exemption may include, but are not limited to, annual gross and net revenues, patient volume, member months, and market share in a given service or geographic region.

(g) "Fully integrated delivery system" means a system inclusive of payer, physician organization, hospital or hospital system, insurance market and line of business, as applicable to that integrated delivery system in a geographic region of the state.

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

(i) "Health care entity" means a payer, as defined in subsection (n), provider, as defined in subsection (p), or fully integrated delivery system, as defined in subsection (f).

(j) "Insurance market" means the public and private insurance markets.

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(k) "Line of business" means the different business lines for the applicable insurance market, as defined in Section 1348.95 of the Health and Safety Code and Section 10127.19 of the Insurance Code.

(l) "Material change" means any change in ownership, operations or governance for health care entities, involving a material amount of assets, occurring through mergers, acquisitions or corporate affiliations involving health care service plans, health insurers, hospitals or hospital systems, physician organizations, and/or pharmacy benefit managers.

(m) "Net cost of health coverage" or "administrative costs and profits" means the costs associated with the administration of health coverage, and is defined as the difference between the premiums received by a payer and expenditures for covered benefits.

(1) For health care service plans and health insurers, the net cost of health coverage is derived from all costs not attributable to the numerator of the Medical Loss Ratio calculation, as defined in section 10112.25(a) of the Insurance Code and section 1367.003(a) of the Health & Safety Code, respectively.

(n) "Office" means the Office of Health Care Affordability, established by Section [4].

(o) "Payer" means private and public health care payers, including:

(1) A health care service plan or a specialized health care service plan, as defined in the Knox-Keene Health Care Service Plan Act (Health and Safety Code Section 1340 et seq.);

(2) A health insurer licensed to provide health insurance, 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; and

(5) Any other public or private entity, other than an individual, that pays or reimburses for any part of the cost for the provision of health care.

(p) "Provider" means an individual, organization, or business entity that provides health care services, including but not limited to, a physician organization (i.e., medical group or independent practice association) or other similar group of providers, health facility, health clinic, including 1206(d) clinics, or other institutions licensed by the state to deliver or furnish health care services.

(q) "Total health care expenditures" means all health care expenditures in the state by public and private sources, including the following:

(1) All payments on providers' claims for reimbursement of the cost of health care provided.

(2) All non-claims based payments to providers.

(3) All cost-sharing paid by residents of this state, including but not limited to copayments, coinsurance and deductibles.

(4) The net cost of health coverage, as defined in this subsection (m).

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Section 3. Legislative Intent

(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 (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%. Meanwhile, families with job-based coverage experienced a 45% increase in premiums, or more than twice the rate of wage growth. During the same period, families experienced a 70% increase in PPO deductibles, or nearly four times the rate of wage growth.

(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 and market power. Consolidation through acquisitions, mergers, or corporate affiliations is pervasive across the industry and involves health care service plans, health insurers, hospitals, physician organizations and pharmacy benefit managers.

(5) Surveys show that people are delaying or going without care due to concerns about cost – or getting care but struggling to pay the resulting bill. In California, one in four people report problems paying or an inability to pay their medical bills, with two-thirds cutting back on basic household items like food and clothing.

(6) High drug prices contribute significantly to health care costs. Prescription drugs account for nearly one-fifth of health care spending, and 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.

(7) 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 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 health care costs while maintaining quality of care, with the goal of improving affordability and equity of health care for Californians.

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

(d) 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 increased investment in primary care and behavioral health, shared risk arrangements and population-based payments.

(e) 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 healthcare workers, and to monitor the effects of cost containment efforts on healthcare workforce stability and training needs of healthcare workers.

(f) It is the intent of the Legislature to fill gaps in California's regulatory framework by reviewing mergers, acquisitions, and corporate affiliations involving health care service plans, health insurers, hospitals or hospital systems, physician organizations, and/or pharmacy benefit managers for impacts on market competition and affordability for consumers and purchasers.

(g) It is the intent of the Legislature to analyze cost 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.

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

(i) It is the intent of the Legislature therefore to establish a single entity within state government charged with developing a comprehensive strategy for cost containment in California, including measuring progress towards lowering per capita health care spending while maintaining quality of care, addressing cost increases in excess of health care cost targets through public transparency, opportunities for remediation, and other progressive enforcement actions commensurate with the offense or violation, and referring transactions that may reduce market competition or increase costs to the Attorney General for further review.

Section 4. Office of Health Care Affordability

(a) There is hereby established within the California Health and Human Services Agency the Office of Health Care Affordability, charged with analyzing the health care market for cost trends and drivers of spending, developing data-informed policies for lowering health care costs for consumers, and creating a state strategy for controlling the cost of health care and ensuring affordability for consumers and purchasers.

(b) The Office may:

(1) Increase cost transparency through public reporting of total health care spending and factors contributing to health care cost growth.

(2) Establish a statewide health care cost target for per capita spending.

(3) Set specific targets by health care sector, including by payer, provider, insurance market, or line of business, as well as geographic region.

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(4) Collect and analyze data from existing and emerging public and private data sources that allows the Office to track spending, set cost targets, approve corrective action plans, and monitor impacts on healthcare workforce stability and carry out all other functions of the Office.

(5) Analyze cost trends in the pharmaceutical sector.

(6) Oversee the state's progress towards the health care cost target by providing technical assistance, requiring public testimony, requiring submission of corrective action plans, and assessing civil penalties, including escalating civil penalties for noncompliance.

(7) Promote and measure quality and health equity through the adoption of a priority set of standard quality measures for assessing health care service plans, health insurers, hospitals, and physician organizations, with consideration for minimizing administrative burden and duplication.

(8) Advance standards for promoting the adoption of alternative payment models.

(9) Advance standards for healthcare workforce stability and training as these relate to costs.

(10) Disseminate best practices from entities that comply with the cost target, including a summary of affordability efforts that enable the entity to meet the cost target.

(11) Address consolidation and market power through cost and market impact reviews of mergers, acquisitions, or corporate affiliations involving health care service plans, health insurers, hospitals, physician organizations and/or pharmacy benefit managers.

(c) The Office shall be headed by a Director, who shall be appointed by and serve at the pleasure of the Governor.

(d) Until January 1, 2025, contracts entered into or amended pursuant to this division are exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and the State Administrative Manual, and are exempt from the review or approval of any division of the Department of General Services.

Section 5. Health Care Affordability Advisory Board

(a) There is hereby established within the Office of Health Care Affordability the Health Care Affordability Board composed of 11 members. Of the 11 members of the advisory board, seven shall be appointed by the Governor, two shall be appointed by the Senate Committee on Rules, and two shall be appointed by the Speaker of the Assembly. The Secretary of Health and Human Services or designee shall serve as an ex officio member of the board.

(b) Members of the board, other than an ex officio member, shall be appointed for a term of four years, except that the initial appointment by the Senate Committee on Rules shall be for a term of five years, and the initial appointment by the Speaker of the Assembly shall be for a term of two years. A member of the board may continue to serve until the appointment and qualification of a successor. Vacancies shall be filled by appointment for the unexpired term. The Governor shall appoint the chair of the advisory board.

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(c) (1) Each person appointed to the board shall have demonstrated and acknowledged expertise in at least one of the following areas: health care economics; health care delivery; health care management or health care finance and administration, including payment methodologies; health plan administration and finance; health care technology; competition in health care markets; primary care; behavioral health, including mental health and substance use disorder services; purchasing or self-funding group health care coverage for employees; enhancing value and affordability of health care coverage; organized labor; or health care consumer advocacy.

(2) Appointing authorities shall consider the expertise of the other members of the board and attempt to make appointments so that the board's composition reflects a diversity of expertise.

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

(d) A board member shall not receive compensation for service on the board, but may receive a per diem and reimbursement for travel and other necessary expenses, as provided in Section 103 of the Business and Professions Code, while engaged in the performance of official duties of the board.

(e) A member of the board shall not make, participate in making, or in any way 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 them or a member of their immediate family, or on any business entity in which the member is a director, officer, partner, trustee, employee, or holds any position of management.

(f) (1) The board shall meet at least quarterly or at the call of the chair.

(2) The board 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).

Section 6. Purpose of the Advisory Board

(a) The advisory board shall advise the Director of the Office of Health Care Affordability on the following:

(1) The establishment of health care cost targets pursuant to Section 7, including the methodology and process for reviewing and updating the targets.

(2) Collection, analysis and public reporting of data for the purposes of implementing this division.

(3) Factors that contribute to cost growth within the state's health care system, including the pharmaceutical sector.

(4) Strategies to improve affordability for both individual consumers and purchasers of health care, including data collection, targets and other steps.

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- (5) Recommendations for administrative simplification in the health care delivery system.
- (6) Approaches for measuring access, quality and equity of care.
- (7) Setting statewide goals and measuring progress for the adoption of alternative payment models and developing standards payers and providers can use during contracting.
- (8) Recommendations for updates to statutory provisions necessary to promote innovation and enable the increased adoption of alternative payment models.
- (9) Healthcare workforce stability and training as these relate to costs.
- (10) Addressing market failures, including consolidation and market power.

Section 7. Health Care Cost Target

- (a) The Director shall establish a statewide health care cost target for total health care expenditures.
- (b) (1) The Director shall have the authority to set specific targets by health care sector and geographic region.
- (2) For this purpose, health care sector may include payer, provider, insurance market, or line of business.
- (A) This subsection shall not apply to exempted providers. The Office shall promulgate regulations for exempted providers with regard to sector specific targets.
- (B) Nothing in the subsection shall be construed to exempt claims and non-claims based payments for exempted providers, and associated cost-sharing amounts paid by consumers, in the calculation of total health care expenditures submitted by payers.
- (3) For this purpose, geographic region may be the regions specified in Health and Safety Code Section 1385.01 or may be otherwise defined.
- (4) The director may have the discretion to adjust cost targets by individual health care entity, when warranted, to account for that entity's baseline costs in comparison to other health care entities in a region or health care sector.
- (5) Targets set for fully integrated delivery systems shall be aggregated inclusive of all health care services, all lines of business and all costs managed by that system in the state.
- (6) Targets set for payers shall also apply to the net cost of health coverage to deter growth in administrative costs and profits. This provision shall not apply to a fully integrated delivery system.
- (7) The setting of different targets shall be informed by historical cost data and other relevant data, as well as access, quality, equity and healthcare workforce stability and quality jobs pursuant to Section 13.

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(c) The health care cost targets shall:

- (1) Promote a predictable and sustainable rate of change in total health care expenditures.
- (2) Be based on established economic indicators.
- (3) Be met by health care entities in the state.
- (4) Be annually reviewed and updated.
- (5) Be developed, applied and enforced with consideration of multiple year rolling averages.
- (6) Improve affordability for consumers and purchasers of health care.

(d) (1) The Director shall establish a methodology to set health care cost targets, including adjustment factors, and the economic indicators to be used in establishing the target.

(2) The targets established for a payer's net cost of health coverage under this section are 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.

(e) The Director shall direct the public reporting of performance on the health care cost targets, which at minimum shall include analysis of changes in total health care costs on an aggregate and per capita basis:

- (1) Statewide;
- (2) By geographic region;
- (3) By insurance market and line of business.
- (4) For payers and providers, both unadjusted and using a standard risk adjustment methodology; and
- (5) For impact on affordability for consumers and purchasers of health care.

(f) For calendar years 2022 and beyond, the Director shall establish a statewide health care cost target in accordance with this section. Calendar year 2022 shall be a reporting year only, and beginning calendar year 2023, applicable cost targets shall be enforced for compliance pursuant to Section 10.

(g) Following the Health Care Affordability Advisory Board's recommendations for cost targets, the Director shall hold a public meeting to discuss the recommendations. The Director shall consider the recommendations of the Advisory Board and public comment. Cost targets and other decisions of the director consistent with this section shall not be adopted, enforced, revised, or updated until presented at a subsequent public meeting. Both of these 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).

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(h) The adoption of cost targets under this section shall be 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).

Section 8. Data Collection

(a) The Office shall have the authority to collect data and other information necessary from health care entities to carry out the functions of the Office, and to the greatest extent possible, may leverage existing and emerging public and private data sources to minimize administrative burdens and duplicative reporting.

(b) The Office shall establish requirements for payers and fully integrated delivery systems to report data and other information necessary to:

(1) Measure health care expenditures.

(2) Determine whether health care entities met health care cost targets.

(3) Identify the annual change in health care costs of health care entities.

(4) Approve and monitor implementation of corrective action plans.

(c) (1) The Office may establish requirements for providers to report data in support of this section as necessary to carry out the functions of the Office.

(2) This subsection shall not apply to exempted providers.

(d) (1) The Office shall develop reporting schedules, technical specifications, and other resources that support the submission of timely data in a standardized format. The Office shall promulgate regulations as necessary to ensure compliance with uniform reporting of total health care expenditures by payers. Prior to adopting regulations and approving the reporting schedules, technical specifications, and other resources, the Office shall engage relevant stakeholders and hold a public meeting.

(2) For the baseline health care spending report published pursuant to Section 9(a), payers shall submit data on total health care expenditures for calendar years 2020 and 2021 no later than December 31, 2022. This initial baseline health care spending report shall serve as baseline data for measuring the statewide cost target effective for calendar year 2022.

(3) For subsequent annual reports, commencing with calendar year 2024, published pursuant to Section 9(b), payers shall submit data on total health care expenditures on the prior calendar year according to the reporting schedule established by the Office.

(e) The Office may consider separate reporting of total health care costs that includes and excludes select high cost prescription drugs.

(e) (1) The Office shall have the authority to require health care service plans, health insurers, hospitals, and physician organizations to report data on the priority set of standard quality measures pursuant to Section 11.

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(2) The Office shall develop reporting schedules, technical specifications, and other resources that support the submission of timely data in a standardized format. The Office shall promulgate regulations as necessary to ensure compliance with uniform reporting on the priority set of measures. Prior to adopting regulations and approving the reporting schedules, technical specifications, and other resources, the Office shall engage relevant stakeholders and hold a public meeting.

(f) (1) The Office shall have the authority to require payers to submit data and other information to measure the adoption of alternative payment models pursuant to Section 12.

(2) The Office shall establish requirements for payers to report data and other information, including but not limited to, the types of payment models, the number of members covered by alternative payment models, the percent of budget dedicated to alternative payments, or cost and quality performance measures tied to such payment models.

(3) The Office shall develop reporting schedules, technical specifications, and other resources that support the submission of timely data in a standardized format. The Office shall promulgate regulations as necessary to ensure compliance with uniform reporting on alternative payment models. Prior to adopting regulations and approving the reporting schedules, technical specifications, and other resources, the Office shall engage relevant stakeholders and hold a public meeting.

(g) The Office shall request data and information from the Department of Managed Health Care, California Department of Insurance and other relevant state agencies that monitor compliance of plans and providers with access standards, including timely access, language access, geographic access, and other access standards as provided by law and regulation.

(h) (1) The Office shall require providers and fully integrated delivery systems to submit audited financial reports as defined in Health and Safety Code Section 128735 paragraphs (a) through (e) if not otherwise required to do under Health and Safety Code Section 128735.

(2) This subsection shall not apply to exempted providers.

(3) Notwithstanding any other provision of law, all information and documents obtained under this section shall not be required to be disclosed pursuant to the California Public Records Act, Chapter 5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code, or any similar local law requiring the disclosure of public records.

(i) (1) The Office shall have the authority to obtain data from existing state data sources and from regulated entities to effectively monitor impacts to healthcare workforce stability and training needs.

(2) The Office may collect the following types of data and make it accessible to the public:

(A) Overall trends in the health care workforce including, but not limited to, statewide and regional workforce supply, unemployment and wage data, trends and projections of wages and compensation, projections of workforce supply by region and specialty, training needs and other coming trends in the health care workforce;

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- (B) The number and classification of workers in internship, clinical placements, apprenticeships and other training programs sponsored by the employer;
 - (C) The percentage of employees employed through a registry or casual employment;
 - (D) The number of workers at health care entities that were retrained through established public training programs; and
 - (E) Investments by health care entities in private training and/or retraining programs.
- (3) The Office may request additional data from health care entities if the Office finds that such data is needed to effectively monitor impacts to healthcare workforce stability and training needs.
- (4) The Office may annually request from health care entities in compliance with cost target a summary of best practices used for improving health care affordability, if any.
- (j) The Office shall adopt emergency regulations for data collection and reporting requirements under this section.

Section 9. Annual Report and Public Meeting

- (a) For data reported to the Office for calendar years 2020 and 2021, the Office shall prepare a report on baseline health care spending consistent with paragraph 2(A) of subsection (b) no later than June 1, 2023.
- (b) (1) Beginning with calendar year 2024, the Office shall prepare and publish an annual report concerning health care spending trends and underlying factors, along with policy recommendations to control costs and improve quality performance and equity of the health care system, while maintaining access to care and high-quality jobs and workforce stability. The report shall be based on the Office's analysis of data collected pursuant to this division and information received by the Office. The first annual report shall cover calendar year 2022.
- (2) The annual report shall detail:
- (A) Total per capita health care expenditures, disaggregated by service category, consumer out-of-pocket spending, and by health care sector, such as payer, provider, insurance market, or line of business, as well as geographic region.
 - (B) Beginning with the annual report for calendar year 2022, the state's progress towards achieving the health care cost target and improving affordability for consumers and purchasers of health care, while improving quality, reducing health disparities, and maintaining access to care and high-quality jobs and workforce stability.
 - (C) Upon implementation of the Health Care Payments Data Program, or the availability of an alternative source of medical claims data for payers required to report to the Office, cost trends by health care sector, such as type of provider, or service type. Any detailed analysis of cost trends in the pharmaceutical sector shall consider the effect of drug rebates and other price concessions in the aggregate without disclosure of any product or manufacturer-specific rebate

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or price concession information, and without limiting or otherwise affecting the confidential or proprietary nature of any rebate or price concession agreement.

(D) Factors that contribute to cost growth within the state's health care system.

(E) Access, quality, and equity of care measures and data, as available. Access includes timely access, language access, geographic access, and other measures of access as reported through available data.

(F) Corrective action plans required and civil penalties imposed and assessed, and amount returned to consumers, if any.

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

(c) (1) For calendar year 2023, the Office shall conduct a public meeting to present the baseline health care spending report to the Health Care Affordability Advisory Board and the broader public. The report on baseline health care spending shall be finalized at a subsequent public meeting.

(2) Beginning with calendar year 2024, and each year thereafter, the Office shall conduct a public meeting to present the annual report to the Health Care Affordability Advisory Board and the broader public. The annual report will inform policymakers, including the Governor and Legislature, and the broader public about implementation of this division, including health care cost targets, cost trends, and actionable recommendations for mitigating cost growth. The annual report shall be finalized at a subsequent public meeting.

(3) The Director may call for public statements on findings of the annual report from payers, providers, and experts on matters relevant to health care affordability, costs, quality and equity of care, workforce stability and administrative simplification.

(4) (A) The Director may solicit and collect comments from the public, submitted orally, electronically, or in writing, regarding any impacts of health care affordability efforts on the healthcare workforce stability or training needs. Persons submitting comments may choose not to identify themselves. All comments shall be posted on the Internet website of the Office.

(B) The Office shall notify the relevant regulators if a health care entity is complying with the cost targets by impacting healthcare workforce stability or quality jobs, lowering quality, or reducing access or equity of care.

(5) The annual report and the report on baseline health care spending shall be submitted to the Governor, the Legislature, and be made available to the public on the Internet website of the Office. The report submitted pursuant to this subsection shall be submitted in compliance with Section 9795 of the Government Code.

(6) The public 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).

Section 10. Enforcement

(a) The Director shall enforce the cost targets established by this Act against health care entities in a manner commensurate with each entity's contribution to cost growth in excess of the applicable target and shall consider the extent to which each entity has control over the applicable components of its cost target. Commensurate with the health care entity's offense or violation, the Director may take the following progressive enforcement actions:

- (1) Provide technical assistance.
- (2) Require public testimony from the health care entity.
- (3) Require submission and implementation of corrective action plans.
- (4) Assess civil penalties, including escalating civil penalties.

(b) (1) If a health care entity exceeds an applicable cost target, the Office shall notify the entity of their status and provide technical assistance.

(2) After providing technical assistance, the Office may require a health care entity to submit a corrective action plan that identifies the causes for spending growth and shall include, but not be limited to, specific strategies, adjustments and action steps the entity proposes to implement to improve spending performance. The Office shall have the authority to request further information as needed in order to approve a proposed corrective action plan.

(3) After approving a corrective action plan, the Office shall identify on its website that the health care entity is implementing a corrective action plan, as well as transmit approved corrective action plans to appropriate state regulators for the entity. Upon the successful completion of the corrective action plan, the identity of the health care entity shall be removed from the website.

(4) All health care entities shall work to implement the corrective action plan. The Office shall monitor the health care entity for compliance with the corrective action plan.

(c) (1) If, after the implementation of a corrective action plan, the health care entity does not meet the cost target, the Director may assess civil penalties commensurate with the failure of the health care entity to meet the target.

(2) The civil penalty may be an amount up to the health care entity's spending in excess of the health care cost target and shall be deposited into the Health Care Affordability Fund.

(3) If, after the implementation of one or more corrective action plans, the health care entity repeatedly exceeds the cost target, the Director may assess escalating civil penalties.

(d) Civil penalties shall not constitute expenditures for the purpose of meeting cost targets. The imposition of civil penalties shall not alter or otherwise relieve the health care entity of the obligation to meet a previously established cost target or a cost target for subsequent years.

(e) (1) For payers, the Director shall enforce cost targets established by Section 7 against the cost growth for the net cost of health coverage. For purposes of this subsection, this provision shall not apply to a fully integrated delivery system.

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(2) If a payer exceeds the target for total health care expenditures, but has met its target for the net cost of health coverage, the payer shall submit relevant documentation or supporting evidence for the drivers of excess cost growth. The Office shall review this information to determine the appropriate health care entity that may be subject to enforcement actions under this section.

(f) If data from multiple sources indicate adverse cost impacts from consolidation and market power, the Director may at any point determine that a cost and market impact review be performed on a health care entity, in addition to the grounds for a cost and market impact review under Section 14.

(g) (1) The Director may assess civil penalties in the event a health care entity has willfully failed to report complete and accurate data, neglected to file a corrective action plan with the Office, failed to file an acceptable corrective action plan with the Office, failed to implement the corrective action plan, or knowingly failed to provide information required by this section to the Office or that knowingly falsifies the same. In determining the amount of the civil penalty, the Office shall consider the nature and number of offenses.

(2) The Director shall refer payers in violation of this subsection to the respective regulator and this shall constitute a violation of the respective licensing law or laws applicable to the payer.

(3) The Director may call a public meeting to notice the public about the health care entity's violation and declare the entity as imperiling the state's ability to monitor and control health care cost growth.

(h) The Office may establish requirements for health care entities to file for a waiver of enforcement actions in this section under extraordinary circumstances. The entity shall submit documentation or supporting evidence of extraordinary circumstances. The Office shall have the authority to request further information as needed in order to approve or deny an application for a waiver.

(i) In implementing this section, the Director shall develop regulations in accordance with the following considerations or principles:

(1) Solicitation of input from a broad range of stakeholders.

(2) Methodology for how enforcement actions and timeline for enforcement will be commensurate with the offense or violation.

(3) Accountability for excessive cost growth to the appropriate health care entity through the use of standard patient attribution methods and statistical techniques for data analysis.

(4) Valid and measureable criteria for examining warranted or unwarranted factors contributing to cost growth in excess of the target.

(5) Unwarranted factors that can reasonably be considered unanticipated and outside the control of the health care entity.

(6) Due process and appeals rights.

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(7) Remittance of civil penalties on health care entities to consumers and purchasers in a feasible, efficient manner using existing state and regulatory processes.

(j) As applied to the civil penalties for acts in violation of this division, the remedies provided by this section and by any other provision of law are not exclusive and may be sought and employed in any combination to enforce this division.

Section 11. Quality Performance

(a) (1) The Office shall adopt a priority set of standard quality measures for assessing health care quality among health care service plans, health insurers, hospitals, and physician organizations. Performance on quality and health equity measures shall be included in the annual report specified in Section 9(b).

(2) The standard quality measure set shall use recognized clinical quality, patient experience, patient safety, and utilization measures for health care service plans, health insurers, hospitals, and physician organizations.

(3) The standard quality measure set shall reflect the diversity of California in terms of race, ethnicity and language, as well as other characteristics including age, gender, sexual orientation and gender identity. The standard quality measure set shall be appropriate for a population under age 65, including children and adults.

(4) The standard quality measure set shall consider available measures for reliable measurement of disparities in health care by race, ethnicity, sexual orientation and gender identity.

(5) The Office shall reduce administrative burden by selecting quality measures that simplify reporting and align performance measurement with other payers and programs.

(b) In implementing this section, the Office shall consult with state departments, external quality improvement organizations and forums, payers, physicians and other providers.

(c) The standard quality measurement set shall be annually reviewed and updated by the Office.

Section 12. Alternative Payment Models

(a) The Office shall promote the shift from payments based on fee-for-service to those rewarding high quality and cost-efficient care. In furtherance of this goal, the Office shall set statewide goals for the adoption of alternative payment models and measure the state's progress.

(b) (1) The Office shall adopt standards for alternative payment models that may be used by providers and payers when contracting.

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

(3) The standards shall include minimum criteria for what is considered an alternative payment model but be flexible enough to allow for innovation and evolution over time.

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(4) The standards shall address appropriate incentives to physicians and other providers and balanced measures including total cost of care and quality requirements to protect against perverse incentives and unintended consequences.

(5) The standards shall attempt to reduce administrative burden by incorporating alternative payment models that align with other payers and programs or national models.

(c) In implementing this section, the Office shall consult with state departments, external organizations promoting alternative payment models, and other entities and individuals with expertise in health care financing and quality measurement.

Section 13. High-Quality Jobs and Healthcare Workforce Stability

(a) The intent of this section is to monitor the effects of cost targets on healthcare workforce stability, high-quality jobs, and training needs of healthcare workers. The intent is for the Office to monitor how health care entities achieve the cost targets and highlight best practices and discourage practices harmful to workers and patients through a process that is transparent and allows for public input.

(b) The Office shall monitor health care costs while promoting healthcare workforce stability and the professional judgment of health professionals, acting within their scope of practice. The Office shall monitor healthcare workforce stability with the goal that workforce shortages do not undermine the goal of health care affordability. The Office shall also promote the goal of health care affordability while recognizing the need to maintain and increase the supply of trained healthcare workers.

(c) To assist health care entities in implementing cost-reducing strategies that advance the stability of the health care workforce, and without exacerbating existing healthcare workforce shortages, the Office shall develop standards in consultation the Health Care Affordability Advisory Board. The standards may be considered in the approval of corrective action plans.

Section 14. Cost and Market Impact Reviews

(a) The Office shall monitor cost trends, including conducting research and studies, on the health care market including, but not limited to, consolidation and market power on competition, prices, access, and quality. In collaboration with the Attorney General, Department of Managed Health Care and California Department of Insurance, as appropriate, the Office shall promote competitive health care markets by examining mergers, acquisitions, or corporate affiliations that entail a material change to ownership, operations or governance structure involving health care service plans, health insurers, hospitals or hospital systems, physician organizations and/or pharmacy benefit managers.

(b) (1) Beginning no later than January 1, 2022, any physician organization, hospital or hospital system, health care service plan, or health insurer that intends to purchase, merge, or consolidate with, initiate a corporate affiliation with, or enter into an agreement resulting in its purchase, acquisition, or control by, any provider, physician organization, hospital or hospital system, pharmacy benefit manager, or any other health care entity, shall give a notification to the Office at least 90 days prior to entering into any proposed material change involving a material amount of assets.

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(2) This section shall apply to both 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.

(3) The Office shall adopt regulations for proposed material changes that warrant a notification, and consider appropriate thresholds, including but not limited to, annual gross and net patient revenues and market share in a given service or region.

(4) The requirement to provide notice of a material change shall not apply to the following:

(A) Mergers and acquisitions only involving health care service plans, which are examined by the Department of Managed Health Care.

(B) Mergers and acquisitions only involving health insurers, which are examined by the Insurance Commissioner.

(5) For notifications of material change that involve nonprofit health facilities or affiliated nonprofit health systems, the Office shall coordinate with Attorney General prior to determining if a cost and market impact review is warranted.

(6) Nothing in this section shall be construed to limit the Attorney General's review of the conversion or restructuring of charitable trusts held by a nonprofit health facility or by an affiliated nonprofit health system.

(c) (1) If the Office finds that the material change is likely to have a significant impact on market competition, the state's ability to meet cost targets, or costs for purchasers and consumers, the Office shall have the authority to conduct a cost and market impact review that may examine factors relating to an entity's business and its relative market position, including, but not limited to: changes in size and market share in a given service or geographic region, prices for services compared to other providers for the same services in the same market, quality, cost, access, or any other factors the Office may determine to be in the public interest.

(2) The Office shall adopt regulations for notification to affected parties for the basis of the review, factors considered in the review, requests for data and information from affected parties and other relevant market participants, and relevant timelines.

(3) Upon completion of the cost and market impact review, the Office shall make factual findings and issue a preliminary report of its findings. After allowing for the affected parties to respond in writing to the findings in the preliminary report, the Office shall issue its final report.

(4) Nothing in this section shall prohibit a proposed material change, however, any proposed material change shall not be completed until at least 30 days after the Office has issued its final report.

(5) The Office may investigate pursuant to and in furtherance of this section, and may compel the entities referenced in subdivision (b)(1), and other relevant market participants, to submit data and documents to the Office.

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(d) The Office shall keep confidential all nonpublic information and documents obtained under this section and shall not disclose the information or documents to any person without the consent of the provider or payer that produced the information or documents, except in a preliminary report or final report under this section if the Office believes that such disclosure should be made in the public interest after taking into account any privacy, trade secret or anti-competitive considerations. Notwithstanding any other provision of law, all nonpublic information and documents obtained under this section shall not be required to be disclosed pursuant to the California Public Records Act, Chapter 5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code, or any similar local law requiring the disclosure of public records.

(e) (1) The Office shall refer its findings, including the totality of documents gathered and data analysis performed, to the Attorney General for further review of unfair methods of competition or anticompetitive behavior.

(2) Nothing in this section shall be construed to limit the authority of the Attorney General to protect consumers in the health care market under any other state law.

Section 15. Health Care Affordability Fund Established

(a) There is hereby established in the State Treasury the Health Care Affordability Fund. All civil penalties assessed for enforcement of the cost target program shall be deposited into the Health Care Affordability Fund.

(b) All monies in the fund, upon appropriation by the Legislature, shall be expended by the Office of Health Care Affordability in a manner that prioritizes the return of the monies to consumers and payers.

(c) The Office may identify any opportunities to leverage existing public and private financial resources to provide technical assistance and support to the Office.

Section 16. Rulemaking Authority

Until January 1, 2026, any necessary rules and regulations for the purposes of implementing this division 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 of the Government Code). The adoption of emergency regulations pursuant to this section shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2, including subdivisions (e) and (h) of Section 11346.1, any emergency regulation adopted pursuant to this section shall be repealed by operation of law unless the adoption, amendment, or repeal of the regulation is promulgated by the Office of Health Care Affordability pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code within five years of the initial adoption of the emergency regulation. Any rule or regulation adopted pursuant to this section shall be discussed by the Office of Health Care Affordability during at least one properly noticed meeting prior to the adoption of the rule or regulation. Notwithstanding subdivision (h) of Section 11346.1, until January 1, 2029, the Office of Administrative Law may approve more than two readoptions of an emergency regulation adopted pursuant to this section.

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Section 17. Severability

The provisions of this division are severable. If any provision or the application of any provision is held to be invalid or unconstitutional, such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions or the application of such provisions.