An act to add Section 1385.035 to, and to add Chapter 2.6 (commencing with Section 127500) to Part 2 of Division 107 of, the Health and Safety Code, and to add Section 10181.35 to the Insurance Code, relating to health care costs.

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

SECTION 1. Section 1385.035 is added to the Health and Safety Code, to read:

1385.035. (a) It is the intent of the Legislature in enacting this section to ensure that enrollees and subscribers benefit from reductions in the rate of growth in health care costs as a result of the establishment of the Office of Health Care Affordability.

(b) In submitting rates for review consistent with this article, a health care service plan shall demonstrate the impact of any changes in the rate of growth in health care costs resulting from the health care cost targets set pursuant to Chapter 2.6 (commencing with Section 127500) of Part 2 of Division 107.

(c) In determining whether a rate is unreasonable or not justified, the director shall consider the impact on changes in health care costs as a result of the health care cost targets set pursuant to Chapter 2.6 (commencing with Section 127500) of Part 2 of Division 107.

SEC. 2. Chapter 2.6 (commencing with Section 127500) is added to Part 2 of Division 107 of the Health and Safety Code, to read:

Chapter 2.6. Health Care Affordability

Article 1. General Provisions and Definitions

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

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

(a) "Affordability for consumers" means considering the totality of costs paid by consumers for covered benefits, including the enrollee share of premium and cost-sharing amounts paid towards the maximum out-of-pocket amount, including deductibles, copays, coinsurance, and other forms of cost sharing for public and private health coverage.

(b) "Affordability for purchasers" means considering the cost to purchasers, including, but not limited to, health plans in the individual market, employers purchasing group coverage, and the state, for health coverage and shall include premium costs, actuarial value of coverage for covered benefits, and the value delivered on health care spending in terms of improved quality and cost efficiency.

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

(d) "Board" means the Health Care Affordability Board established by Section 127501.10.

(e) "Director" means the Director of the Department of Health Care Access and Information.

(f) (1) "Exempted provider" means a provider that meets standards established by the board for exemption from the (A) statewide health care target, or (B) specific targets set for health care sectors, including the fully integrated delivery system sector, and geographic region, and for an individual health care entity. The factors used in setting standards for exemption may include, but are not limited to, annual gross and net revenues, patient volume, and high-cost outliers in a given service or geographic region. In determining whether a provider is an exempted provider, the board shall

also consider any affiliates, subsidiaries, or other entities that control, govern, or are financially responsible for the provider or that are subject to the control, governance, or financial control of the provider.

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

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

(h) "Geographic region" may either be the regions specified in Section 1385.01 or may be otherwise defined by the office.

(i) "Health care cost target" means the target percentage for the annual increase in per capita total health care expenditures.

(j) "Health care entity" means a payer, provider, or a fully integrated delivery system.

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

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

(m) "Material change" means any change in ownership, operations, or governance for a health care entity, involving a material amount of assets of a health care entity.

(n) (1) "Net cost of health coverage" means the difference between the premiums and other amounts received by a payer and the expenditures for covered benefits.

(2) For purposes of this subdivision, for health plans and insurers, "other amounts received" includes other sources of income a payer received under the terms of the contract for health coverage or insurance or per the terms of the payer's contracts or arrangements with health care providers or delegated entitles.

(3) For purposes of this subdivision, "expenditures for covered benefits" consist of all of the following:

(A) For health plans and insurers, all categories of administrative expenditures, as included in the medical loss ratio defined in subdivision (a) of Section 1367.003 of this code and subdivision (a) of Section 10112.25 of the Insurance Code, respectively.

(B) Net additions to reserves.

(C) Rate dividends or rebates to purchasers.

(D) Profits or losses.

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

(1) A health care service plan or a specialized health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2).

(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.

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

(p) "Per capita total health care expenditures" means total health care expenditures, as defined in subdivision (t), divided by the number of covered lives or enrollees reported by payers.

(q) "Physician organization" includes any of the following:

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

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

(3) An independent practice association that negotiates contracts with one or more payers on behalf of a group of independent providers.

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

(5) Any of the following entities that employs or contracts with, or has a similar arrangement with, a substantial number of physicians and surgeons to provide, deliver, furnish, or otherwise arrange for health care services, except for risk-bearing organizations and independent practice organizations:

(A) A medical group practice, including a professional medical corporation, as defined in Section 2406 of the Business and Professions Code.

(B) A lawfully organized group of physicians and surgeons that delivers, furnishes, or otherwise arranges for health care services in any organizational form consistent with state law, including, but not limited to, a medical partnership or professional medical corporation.

(6) For the purposes of paragraph (5), "a substantial number of physicians and surgeons" means the following:

(A) Sixty or more physicians for entities comprised of primary care physicians.

(B) Fifty or more physicians for entities comprised of primary care and specialty physicians.

(C) Forty or more physicians for entities comprised of specialty physicians.

(7) Notwithstanding paragraph (6), an organization described in subparagraph (A) or (B) of paragraph (5) that does not meet the definition of having a substantial number of physicians and surgeons, but is a high-cost outlier whose costs for the services provided are substantially higher compared to the statewide average, as identified through data sources that include, but are not limited to, data from state and federal agencies, other relevant supplemental data, such as financial data on providers that is submitted to state agencies, or data reported to HCAI under the Health Care Payments Data Program, established pursuant to Chapter 8.5 (commencing with Section 127671).

(r) "Provider" means any of the following that delivers or furnishes health care services:

(1) A physician organization.

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

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

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

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

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

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

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

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

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

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

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

(2) All non-claims-based payments for covered health care benefits, such as capitation, salary, global budget, or other alternative payment methods.

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

(4) The net cost of health coverage.

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

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

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

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

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

(4) Escalating health care costs are being driven primarily by high prices and the underlying factors or market conditions that drive prices, particularly in geographic areas and sectors where there is a lack of competition due to consolidation, market

power, venture capital activity, the role of profit margins, and other market failures. Consolidation through acquisitions, mergers, or corporate affiliations is pervasive across the industry and involves health care service plans, health insurers, hospitals, physician organizations, pharmacy benefit managers, and other health care entities. Further, market consolidation occurs in various forms, including horizontal, vertical, and cross industry mergers, transitions from nonprofit to for-profit status or vice versa, and any combination involving for-profit and nonprofit entities, such as a nonprofit entity merging with, acquiring, or entering into a corporate affiliation with a for-profit entity or vice versa.

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

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

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

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

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

during the economic recession related to the COVID-19 pandemic, particularly among lower-wage workers.

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

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

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

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

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

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

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

(g) It is the intent of the Legislature that health care cost targets not be used to avoid collective bargaining, and that cost targets not be used to place a floor or ceiling on health care workforce compensation.

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

(i) It is the intent of the Legislature to analyze cost and quality trends in the pharmaceutical sector, study the impact of drug prices and pharmaceutical market

failures on affordability, and inform policy interventions to improve competition and lower consumer costs.

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

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

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

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

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

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

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

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

Article 2. Office of Health Care Affordability

127501. (a) There is hereby established, within the Department of Health Care Access and Information, the Office of Health Care Affordability.

(b) The office shall be responsible for analyzing the health care market for cost trends and drivers of spending, developing data-informed policies for lowering health care costs for consumers and purchasers, creating a state strategy for controlling the cost of health care and ensuring affordability for consumers and purchasers, and enforcing cost targets.

(c) The office shall do all of the following:

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

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

(3) Set specific health care cost targets by health care sector, including a fully integrated delivery system sector and geographic region, and for an individual health care entity, as appropriate.

(4) Collect and analyze data from existing and emerging public and private data sources that allow the office to track spending, set cost targets, approve performance improvement plans, monitor impacts on health care workforce stability, and carry out all other functions of the office.

(5) Analyze cost and quality trends for drugs covered by pharmaceutical and medical benefits. The office shall consider the data in the reports required pursuant to Section 1367.243 and Section 10123.205 of the Insurance Code and pharmaceutical data reported in the Health Care Payments Data Program, established pursuant to Chapter 8.5 (commencing with Section 127671).

(6) Oversee the state's progress towards meeting the health care cost target by providing technical assistance, requiring public testimony, requiring submission of and monitoring compliance with performance improvement plans, and assessing administrative penalties through enforcement actions, including escalating administrative penalties for noncompliance.

(7) Promote, measure, and publicly report performance on quality and health equity through the adoption of a priority set of standard quality and equity measures for health care entities, with consideration for minimizing administrative burden and duplication.

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

(9) Measure and promote sustained systemwide investment in primary care and behavioral health.

(10) Advance standards for health care workforce stability and training, as these relate to costs.

(11) 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.

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

(13) Analyze trends in the price of health care technologies.

(14) Analyze trends in the cost of labor for both management and administration, as well as nonsupervisorial health care workforce, as well as analyzing the profits of health care entities, if that data is available.

(15) Conduct ongoing research and evaluation on payers and providers, including physician organizations, to determine whether the definitions or other provisions of this chapter include those entities that significantly affect health care cost, quality, equity, and workforce stability.

(16) Adopt and promulgate regulations for the purpose of carrying out this chapter.

(d) For purposes of implementing this chapter, including hiring staff and consultants, through the procurement authority and processes of the department, facilitating and conducting meetings, conducting research and analysis, and developing the required reports, the office may enter into exclusive or nonexclusive contracts on

a bid or negotiated basis. Until January 1, 2026, contracts entered into or amended pursuant to this chapter are exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 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.

127501.2. (a) Until January 1, 2027, any necessary rules and regulations for the purpose of implementing this chapter 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.

(b) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, including subdivisions (e) and (h) of Section 11346.1, an 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 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.

(c) Any rule or regulation adopted pursuant to this section shall be discussed by the office during at least one properly noticed meeting prior to the adoption of the rule or regulation.

127501.3. (a) The office shall be responsive to requests for additional information from the Legislature, including providing testimony during hearings and commenting on proposed legislation or policy issues.

(b) The Legislature finds and declares that activities, including, but not limited to, responding to legislative or executive inquiries, tracking and commenting on legislation and regulatory activities, and preparing reports on the implementation of this chapter and the performance of the office, are necessary state requirements.

127501.4. (a) (1) Notwithstanding any other state or local law, the office shall collect data and other information it determines necessary from health care entities, except exempted providers, to carry out the functions of the office. To the extent consistent with federal law and to the greatest extent possible, the office may use existing and emerging public and private data sources to minimize administrative burdens and duplicative reporting, including data or information from federal agencies as well as state agencies. The office may request data and information from, or enter into a data sharing agreement with, the State Department of Health Care Services, the Department of Managed Health Care, the Department of Insurance, the Labor and Workforce Development Agency, the Business, Consumer Services, and Housing Agency, 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. The office may also enter into a data sharing agreement with these state agencies that collect payer and provider financial data or other data or information about the health care workforce.

(2) In furtherance of this chapter, and with the intent to reduce administrative burdens, the office shall coordinate with the State Department of Health Care Services on data and other information necessary to report both of the following:

(A) Total health care expenditures and per capita total health care expenditures for services paid for outside of Medi-Cal managed care plans.

(B) Quality and equity measures to assess performance for the Medi-Cal program or other programs administered by the State Department of Health Care Services.

(3) (A) The office shall obtain from the Department of Managed Health Care and the Department of Insurance information about health care services plans, as defined in subdivision (b) of Section 1345, and insurers offering policies of health insurance, as defined in subdivision (b) of Section 106 of the Insurance Code. The information shall be for coverage in the individual, small group, and large group markets for both grandfathered and nongrandfathered products. The information shall include, but not be limited to, all of the following:

(i) Information on premiums, cost sharing, benefits, and other information required under Article 6.2 (commencing with Section 1385.01) of Chapter 2.2 of Division 2 of this code and Article 4.5 (commencing with Section 10181) of Chapter 1 of Part 2 of Division 2 of the Insurance Code.

(ii) Trend factors by benefit category, such as inpatient hospitalization and physician services, including price, utilization, and cost as a percentage of Medicare, as required by Section 1385.045 of this code and Section 10181.45 of the Insurance Code.

(iii) Medical loss ratio for each health care service plan or health insurer, consistent with Section 1367.003 of this code and Section 10112.25 of the Insurance Code.

(iv) Cost containment and quality improvement efforts reported consistent with Sections 1385.03 and 1385.045 of this code and Sections 10181.3 and 10181.45 of the Insurance Code.

(v) Prescription drug costs consistent with Section 1367.243 and Article 6.1 (commencing with Section 1385.001) of Chapter 2.2 of Division 2 of this code and Section 10123.205 of the Insurance Code.

(vi) Information regarding health equity and quality required under Article 11.9 (commencing with Section 1399.870) of Chapter 2.2 of Division 2, including data and results.

(B) The Department of Managed Health Care and the Department of Insurance shall provide the above information in the initial submission of data to the office for the five years prior to 2023, to the extent that information is available, and annually thereafter.

(4) The office may obtain from the California Health Benefit Exchange information about its enrollees and may enter into a data sharing agreement with the exchange in order to carry out the functions of the office.

(b) The office shall establish requirements for payers to submit data and other information necessary to do all of the following:

(1) Measure total health care expenditures and per capita total 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 performance improvement plans.

(5) Assess performance on quality and equity measures.

(c) The office shall, in a manner prescribed by the office, establish requirements for providers to submit data in support of this section as necessary to carry out the functions of the office.

(d) (1) For the purpose of publicly reporting the impact of COVID-19 on health care spending in the state, payers shall submit aggregate data on total health care expenditures for the 2019, 2020, and 2021 calendar years on or before July 1, 2023. Enforcement shall not be implemented for this report on the impact of COVID-19, except any enforcement actions necessary to ensure compliance with the deadline for submitting data.

(2) For the purpose of the baseline health care spending report published pursuant to subdivision (b) of Section 127501.6, payers shall submit data on total health care expenditures for the 2022 and 2023 calendar years on or before December 31, 2024. Enforcement shall not be implemented for the targets established pursuant to this baseline report, except any enforcement actions necessary to ensure compliance with the deadline for submitting data.

(3) For the first annual report, published pursuant to subdivision (c) of Section 127501.6, payers shall submit data on total health care expenditures for the 2024 calendar year on or before December 31, 2025. For subsequent annual reports, payers shall submit data for the relevant calendar years according to the reporting schedule established by the office.

(e) (1) The office shall require payers and providers to submit data and other information as necessary to fulfill its functions and measure total health care expenditures and per capita total health care expenditures by sectors.

(2) For the calculation of total health care expenditures and per capita total health care expenditures by sectors, the office shall use the Health Care Payments Data Program, established pursuant to Chapter 8.5 (commencing with Section 127671), to the greatest extent possible, to minimize reporting burdens for payers and providers, and may also use data from federal agencies.

(f) The office shall require health care service plans, health insurers, hospitals, and physician organizations to report data and other information, as necessary, for the single set of standard quality measures pursuant to Section 127503.

(g) (1) The office shall require payers to submit data and other information to measure the adoption of alternative payment models pursuant to Section 127504.

(2) The office shall establish requirements for payers to report data and other information, including, but not limited to, the types of payment models, adoption by line of business, 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 those payment models.

(h) (1) The office shall require payers to submit data and other information to measure the percentage of total health care expenditures allocated to primary care and behavioral health pursuant to Section 127505.

(2) For the calculation of total health care expenditures allocated to primary care and behavioral health, the office shall do all of the following:

(A) Use the Health Care Payments Data Program, established pursuant to Chapter 8.5 (commencing with Section 127671), to the greatest extent possible, to minimize reporting burdens for payers and providers.

(B) Determine the categories of health care professionals who should be considered primary care and behavioral health providers and consider existing state and national approaches, as appropriate.

(C) Determine specific procedure codes that should be considered primary care and behavioral health services and consider existing state and national approaches, as appropriate.

(D) Determine the categories of payments to primary care or behavioral health care providers and practices, including non-claims-based payments, such as alternative payment models, that should be included when determining the total amount spent on primary care and behavioral health.

(i) (1) With consideration to minimizing reporting burdens and expenses, the office shall require providers to submit audited financial reports, similar to those required in paragraphs (a) to (e), inclusive, of Section 128735. This paragraph does not apply to exempted providers.

(2) For physician organizations defined in paragraph (2) of subdivision (q) of Section 127500, and providers that do not routinely prepare audited financial reports, the office shall require a comprehensive financial statement that includes details regarding annual costs, annual receipts, realized capital gains and losses, and accumulated surplus and accumulated reserves. The comprehensive financial statement shall be supported by sworn written declarations by both the chief financial officer and chief executive officer or, if applicable, by each general partner, or each managing member and manager, certifying that the financial statement is complete, true, and correct in all material matters to the best of their knowledge, and that the provider does not routinely prepare audited financial reports. This paragraph does not apply to exempted providers and physician organizations that are part of a fully integrated delivery system.

(3) The board, the office, and the office's employees, contractors, and advisors shall keep the audited financial reports and comprehensive financial statements confidential, and shall use the confidential information and documents only as necessary for the function of the office.

(4) This subdivision does not apply to providers that are already required to report under Section 128735.

(5) Notwithstanding any other law, all information and documents obtained under this subdivision shall not be required to be disclosed pursuant to the California Public Records Act (Chapter 3.5 (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.

(j) (1) Consistent with subdivision (a), the office shall obtain data from existing state and federal data sources and from regulated entities to effectively monitor impacts to health care workforce stability and training needs.

(2) In order for an adjustment to cost targets to be made under paragraph (7) of subdivision (c) of Section 127502, a provider, fully integrated delivery system, or other associated party shall produce actual or projected nonsupervisory employee labor costs, including increased expenditures related to compensation, and any other supporting

information to validate the adjustment, as may be requested by the office pertaining to the actual or projected labor costs.

(3) The office may collect all of 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 future trends in the health care workforce.

(B) The number and classification of workers in internship, clinical placements, apprenticeships, and other training programs sponsored by an 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.

(E) Investments by health care entities in private training and retraining programs.

(F) The number of workers subject to relocation, termination, or mass layoff as described in Chapter 4 (commencing with Section 1400) of Part 4 of Division 2 of the Labor Code.

(4) The office may request additional data from health care entities if it finds that the data is needed to effectively monitor impacts to health care workforce stability and training needs.

(5) The office may annually request from health care entities that are in compliance with the cost target, a summary of best practices used for improving health care affordability, if any.

(k) In furtherance of this section, the office shall develop reporting schedules, technical specifications, and other resources that support the submission of timely data in a standardized format. Prior to adopting regulations and approving the reporting schedules, technical specifications, and other resources, the office shall engage relevant stakeholders, hold a public meeting to solicit input, and provide a response to input received.

127501.6. (a) For data submitted to the office pursuant to paragraph (1) of subdivision (d) of Section 127501.4, the office shall prepare a report consistent with subparagraph (A) of paragraph (2) of subdivision (c) on or before June 1, 2024.

(b) For data submitted to the office under paragraph (2) of subdivision (d) of Section 127501.4, the office shall prepare a report on baseline health care spending consistent with subparagraph (A) of paragraph (2) of subdivision (c) on or before June 1, 2025.

(c) (1) On or before June 1, 2026, the office shall prepare and publish its first annual report concerning health care spending trends and underlying factors, for the 2024 calendar year, 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 and other information collected pursuant to this chapter.

(2) The annual report shall include all of the following:

(A) Total health care expenditures and per capita total health care expenditures, disaggregated by service category, consumer out-of-pocket spending, and health care sector or geographic region, as specified in Section 127502.

(B) 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 pursuant to Chapter 8.5 (commencing with Section 127671), or the availability of an alternative source of health care spending data for payers required to report to the office, drivers of overall cost and cost growth, including cost trends by health care sector, such as type of provider or service type. Alternative sources of data shall include, but not be limited to, data provided to existing multipayer claims databases or other state or federal agencies. 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 disclosing any product- or manufacturer-specific rebate 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 reported through available data.

(F) Performance improvement plans required, administrative penalties imposed and assessed, and the amount returned to consumers and purchasers, if any.

(G) A summary of best practices for improving affordability while maintaining access, quality, and equity of care, as well as any concerns regarding impacts on the health care workforce stability and training needs of health care workers, as feasible.

(d) (1) Prior to and following the completion of the report on baseline health care spending, the office shall present the report's findings to the board and the broader public at a public meeting of the board. The report on baseline health care spending shall be finalized at a subsequent public meeting.

(2) On or before July 1, 2026, and at least 30 days after posting a draft of the annual report, and each year thereafter, the office shall present the annual report at a public meeting of the board to inform the board, policymakers, including the Governor and the Legislature, and the broader public about implementation of this chapter, 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 shall call for public statements on findings of the annual report from payers, providers, and experts on matters relevant to health care affordability, costs, quality, access, and equity of care, workforce stability, and administrative simplification.

(4) The director shall also seek comments from purchasers, including consumer advocacy organizations, organizations representing employers who purchase health coverage, but that exclude providers, and representatives of trust funds and other self-insured purchasers of health benefits.

(5) (A) The director shall solicit and collect comments from the public, submitted orally, electronically, or in writing, regarding any impacts of health care affordability efforts on health care workforce stability or training needs. All comments may be

posted on the office's internet website to the extent that they are in compliance with state guidelines for the appropriateness of communications.

(B) The office shall notify the relevant regulatory agency and the Attorney General if a health care entity is impacting health care workforce stability or quality jobs, lowering quality, or reducing access or equity of care.

(e) The annual report and the report on baseline health care spending shall be submitted to the Governor and the Legislature and shall be made available to the public on the office's internet website, along with key data and statistics supporting its findings. The reports submitted pursuant to this section shall be submitted in compliance with Section 9795 of the Government Code.

(f) 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).

127501.7. (a) (1) Notwithstanding any other law regarding the confidentiality of data submitted by health care service plans or other entities to the Department of Managed Health Care, the office and the Department of Managed Health Care may enter into an interagency agreement for the transfer of data pursuant to Section 127501.4 and any other data maintained by the Department of Managed Health Care deemed necessary by the office to implement this chapter.

(2) The interagency agreement shall specify that the office shall comply with any confidentiality requirements of the data that would otherwise apply to the Department of Managed Health Care with respect to disclosure. When confidentiality of data applies, the office may aggregate data for disclosure so that it does not reveal information specific to individual health care service plans or other entities.

(b) (1) Notwithstanding any other law regarding the confidentiality of data submitted by health insurers or other entities to the Department of Insurance, the office and the Department of Insurance may enter into an interagency agreement for the transfer of data pursuant to Section 127501.4 and any other data maintained by the Department of Insurance deemed necessary by the office to implement this chapter.

(2) The interagency agreement shall specify that the office shall comply with any confidentiality requirements of the data that would otherwise apply to the Department of Insurance with respect to disclosure. When confidentiality of data applies, the office may aggregate data for disclosure so that it does not reveal information specific to any particular health insurer or other entity.

127501.8. (a) There is hereby established in the State Treasury the Health Care Affordability Fund for the purpose of receiving and expending revenues collected pursuant to this chapter. This fund is subject to appropriation by the Legislature.

(b) All moneys in the fund shall be expended in a manner that prioritizes the return of the moneys to consumers and purchasers.

(c) The office may identify any opportunities to leverage existing public and private financial resources to provide technical assistance to health care entities and support to the office. Any private or public moneys obtained may be placed in the Health Care Affordability Fund, for use by the office upon appropriation by the Legislature.

127501.10. (a) There is hereby established, within the office, the Health Care Affordability Board. The board shall be composed of eight members, as follows:

(1) Four members shall be appointed by the Governor and confirmed by the Senate.

(2) One member shall be appointed by the Senate Committee on Rules.

(3) One member shall be appointed by the Speaker of the Assembly.

(4) The Secretary of Health and Human Services or their designee.

(5) The CalPERS Chief Health Director or their deputy shall serve as a nonvoting member of the board.

(b) Members of the board who are appointed 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, the initial appointment by the Speaker of the Assembly shall be for a term of two years, and one of the initial appointments by the Governor shall be for a term of three 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.

(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; or organized labor that represents health care workers.

(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 and includes representation of payers, providers, purchasers, and consumer advocates who also meet the requirements of paragraph (1).

(3) In making appointments to the board, the appointing authorities shall take into consideration the state's diversity in culture, race, ethnicity, sexual orientation, gender identity, and geography so that the board's composition reflects the communities of California. Appointing authorities shall consider the experience the board member has as a patient or caregiver of a patient with an ongoing chronic condition.

(4) A majority of the board shall consist of appointees that do not receive financial compensation from providers or payers that are subject to the cost targets or cost and market impact reviews or from exempted providers.

(5) The board shall elect a chair.

(d) (1) Each member of the board shall receive a per diem of five hundred dollars ($500) for each day actually spent in the discharge of official duties, not to exceed 30 days per year, and shall be reimbursed for traveling and other expenses necessarily incurred in the performance of official duties. After June 30, 2025, the per diem shall be one hundred dollars ($100) per day.

(2) Notwithstanding any other law, a public officer or employee shall not receive per diem salary compensation for serving on the board on any day when the officer or employee also received compensation for their regular public employment.

(e) (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), except that the board may hold closed sessions when considering

matters related to the office assessing administrative penalties and requiring performance improvement plans under Section 127502.5.

(3) The board shall be subject to Article 3 (commencing with Section 87300) of Chapter 7 of Title 9 of the Government Code, and the regulations promulgated thereunder.

127501.11. (a) The board shall establish all of the following:

(1) A statewide health care cost target.

(2) The definitions of health care sectors and geographic regions and specific targets by health care sector, including the fully integrated delivery system sector and geographic region, and for an individual health care entity, as appropriate.

(3) The standards that need to be met for exemption from health care cost targets or submitting data directly to the office, including the definition of exempted providers.

(b) The board shall approve all of the following:

(1) Methodology for setting cost targets and adjustment factors to modify cost targets when appropriate.

(2) The scope and range of administrative penalties and the penalty justification factors for assessing penalties.

(3) The benchmarks for primary care and behavioral health spending.

(4) The statewide goals for the adoption of alternative payment models and standards that may be used between payers and providers during contracting.

(5) The standards to advance the stability of the health workforce that may apply in the approval of performance improvement plans.

(c) The director shall present to the board for discussion all of the following:

(1) Options for statewide health care cost targets, specific targets by health care sector, including the fully integrated delivery system and geographic region, and for an individual health care entity, as appropriate.

(2) The collection, analysis, and public reporting of data for the purposes of implementing this chapter.

(3) The risk adjustment methodologies for the reporting of data on total health care expenditures and per capita total health care expenditures.

(4) Review and input on performance improvement plans prior to approval, including delivery of periodic updates about compliance with performance improvement plans.

(5) Review and input on administrative penalties to be assessed.

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

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

(8) Recommendations for administrative simplification in the health care delivery system.

(9) Approaches for measuring access, quality, and equity of care.

(10) Recommendations for updates to statutory provisions necessary to promote innovation and to enable the increased adoption of alternative payment models.

(11) Methods of addressing consolidation, market power, and other market failures.

(d) (1) To support the board's decisionmaking, the board may request data analysis to be conducted or collected by the office.

(2) The office may establish advisory or technical committees, as necessary. The office shall establish advisory or technical committees at the request of the board. These committees may be standing committees or time-limited workgroups, at the discretion of the board. Members of these committees shall comply with the requirements in paragraph (1) of subdivision (c) of Section 127501.10. A committee established by the board may include members who are payers, providers, physician organizations, consumer organizations representing health care consumers or patients, organized labor representing health care workers, or patients or caregivers of patients with a chronic condition requiring ongoing health care, which may include behavioral health care.

Article 3. Health Care Cost Targets

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

(b) (1) The board shall set specific targets for each health care sector, including a fully integrated delivery system sector and geographic region, and for an individual health care entity as appropriate. The board shall define the health care sectors and the office shall promulgate regulations accordingly.

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

(3) The setting of different targets by health care sector, including the fully integrated delivery system sector and geographic region, and for an individual health care entity, as appropriate, shall be informed by historical cost data and other relevant supplemental data, such as financial data on payers and providers submitted to state agencies and the Health Care Payments Data Program, as well as consideration of access, quality, equity, and health care workforce stability and quality jobs pursuant to Section 127505.

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

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

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

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

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

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

(4) Be developed, applied, and enforced.

(5) Promote the goal of improved affordability for consumers and purchasers of health care, while maintaining quality and equitable care.

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

(7) Adjust a provider or fully integrated delivery system's cost target upon a showing that nonsupervisory employee labor costs are projected to grow faster than the rate of any applicable cost targets.

(d) (1) Consistent with paragraph (1) of subdivision (b) of Section 127501.11, the director shall develop a methodology to set health care cost targets, including consideration of economic indicators and population-based measures to be used in establishing the target and adjustment factors. The methodology shall be available and transparent to the public.

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

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

(4) In order to identify potential adjustment factors to cost targets, the methodology for setting cost targets shall review the health care employment cost index, labor costs, the consumer price index for urban wage earners and clerical workers, impacts due to known emerging diseases, trends in the price of health care technologies, provider payer mix, state or local mandates such as required capital improvement projects, and any relevant state and federal policy changes impacting provider reimbursement and costs.

(5) The methodologies shall consider provider-related provision of nonfederal share, determined to be appropriate by the Director of Health Care Services, associated with Medi-Cal payments, such as expenditures by providers or provider-affiliated entities that serve as the nonfederal share associated with Medi-Cal reimbursement. The board may also consider provision of nonfederal share that is not associated with specific Medi-Cal reimbursement but that supports Medi-Cal coverage, and any other administrative fees assessed by the State Department of Health Care Services, as determined appropriate by the Director of Health Care Services.

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

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

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

(i) Cost and quality performance data reported by or sourced from recognized quality improvement and transparency initiatives, such as the Center for Data Insights and Innovation's Office of Patient Advocate, the Integrated Healthcare Association, and Cal Hospital Compare.

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

(iii) Any relevant federal data.

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

(e) The methodology for setting cost targets for an individual health care entity shall be developed taking into account both of the following:

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

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

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

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

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

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

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

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

(g) In consultation with the board, the director shall establish equity adjustment methodologies to take into account social determinants of health and other factors related to health equity, to the extent data is available and methodology has been developed and validated.

(h) (1) Targets set for payers shall also apply to the net cost of health coverage to deter growth in administrative costs and profits.

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

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

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

(j) The director shall direct the public reporting of performance on the health care cost targets, which may include analysis of changes in total health care expenditures on an aggregate and per capita basis for all of the following:

(1) Statewide.

(2) By geographic region.

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

(4) For payers and providers, both unadjusted and using a risk adjustment methodology against the covered lives or patient population for which they are primarily responsible.

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

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

(*l*) (1) The board shall establish a statewide health care cost target beginning with the 2025 calendar year and for each calendar year thereafter. The 2025 baseline target shall be a reporting year only and shall not be subject to enforcement pursuant to Section 127502.5. The targets established for the 2026 calendar year, and each calendar year thereafter, shall be enforced for compliance pursuant to Section 127502.5.

(2) On or before January 1, 2027, the board shall define health care sectors and geographic regions, considering factors such as delivery system characteristics, including a fully integrated delivery system sector or sectors. Not later than the 2028 calendar year, the board shall set specific targets by health care sector, including the fully integrated delivery system sector and geographic region, and for any individual health care entity, as appropriate, in accordance with this chapter.

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

(B) Targets adopted under this subdivision shall specify which single cost target is applicable if a health care entity falls within two or more sectors.

(m) (1) The board shall hold a public meeting to discuss the development and adoption of recommendations for statewide cost targets, or specific targets by health care sector, including the fully integrated delivery system sector and geographic region, and for an individual health care entity. The board shall deliberate and consider public comment. Cost targets and other decisions of the board consistent with this section shall not be adopted, enforced, revised, or updated until presented at a subsequent public meeting. Both 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).

(2) The board shall adopt recommendations at a public meeting for proposed targets on or before April 1 of the year prior to the applicable target year.

(3) The board shall hold a public meeting no sooner than 15 days, and no later than 45 days, after the board makes its recommendations for proposed targets.

(4) The board shall adopt final targets on or before June 30 of the year prior to the applicable calendar year. If, at the last scheduled board meeting prior to June 30, the board has not adopted final cost targets required for the following calendar year, the board shall remain in session, and members shall not receive per diem under Section 127501.10, until the board adopts all required cost targets for the following calendar year.

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

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

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

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

(q) In implementing this article, the office shall collaborate with the Department of Managed Health Care to align with requirements under Article 11.9 (commencing with Section 1399.870) of Chapter 2.2 of Division 2 and shall consult with state departments, external quality improvement organizations and forums, payers, physicians, other providers, and consumer advocates or stakeholders with expertise in quality or equity measurement.

127502.5. (a) The director shall enforce the cost targets established by this chapter against health care entities in a manner that ensures compliance with targets, allows each health care entity opportunities for remediation, and ensures health care entities do not implement performance improvement plans in ways that are likely to erode access, quality, equity, or workforce stability. The director shall consider each entity’s contribution to cost growth in excess of the applicable target, factors that contribute to spending in excess of the applicable target, and 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 to the entity to assist it to come into compliance.

(2) Require or compel public testimony by the health care entity regarding its failure to comply with the target.

(3) Require submission and implementation of performance improvement plans, including review and input from the board prior to approval.

(4) Assess administrative penalties in amounts initially commensurate with the failure to meet the targets, and in escalating amounts for repeated or continuing failure to meet the targets.

(b) Prior to taking any enforcement action, the office shall do all of the following:

(1) Notify the health care entity that it has exceeded the health care cost target.

(2) Give the health care entity not less than 45 days to respond and provide additional data, including information in support of a waiver described in subdivision (i).

(3) If the office determines that the additional data and information meets the burden established by the office to explain all or a portion of the entity's cost growth in excess of the applicable target, the office may modify its findings, as appropriate.

(4) The director shall consult with the Director of Managed Health Care or the Insurance Commissioner, as applicable, prior to taking any of the enforcement actions specified in this section with respect to a payer regulated by the respective department to ensure any technical assistance, performance improvement plans, or other measures authorized by this section are consistent with laws applicable to regulating health care service plans and health insurers.

(c) (1) If a health care entity exceeds an applicable cost target, the office shall notify the entity of their status and provide technical assistance. The office shall make public the extent to which the entity exceeded the target. The office may require a health care entity to submit and implement a performance improvement 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 during a specified time period. The performance improvement plan shall include a summary, which shall be made publicly available. The office shall request further information, as needed, in order to approve a proposed performance improvement plan. The office may approve a performance improvement plan consistent with those areas requiring specific performance or correction for up to three years. The office shall not approve a performance improvement plan that proposes to meet cost targets in ways that are likely to erode access, quality, equity, or workforce stability. The standards developed under Article 7 (commencing with Section 127506) may be considered in the approval of a performance improvement plan.

(2) The office shall monitor the health care entity for compliance with the performance improvement plan. The office shall publicly post the identity of a health care entity completing a performance improvement plan and a summary of the performance improvement plan while the plan remains in effect and shall transmit an approved performance improvement plan to appropriate state regulators for the entity.

(3) A health care entity shall work to implement the performance improvement plan as submitted to, and approved by, the office. The office shall monitor the health care entity for compliance with the performance improvement plan.

(4) The office, the board, and the members of the board shall keep confidential all nonpublic information and documents obtained under this subdivision, and shall not disclose the confidential information or documents to any person, other than the Attorney General, without the consent of the source of the information or documents, except in an administrative penalty action, or a public meeting under this section if the office believes that disclosure should be made in the public interest after taking into account any privacy, trade secret, or anticompetitive considerations. Prior to disclosure in a public meeting, the office shall notify the relevant party and provide the source of nonpublic information an opportunity to specify facts documenting why release of the information is damaging or prejudicial to the source of the information and why the public interest is served in withholding the information. Information that is otherwise publicly available, or that has not been confidentially maintained by the source, shall not be considered nonpublic. This paragraph does not limit disclosures made in closed sessions of board meetings.

(5) Notwithstanding any other law, all nonpublic information and documents obtained under this subdivision shall not be required to be disclosed pursuant to the California Public Records Act (Chapter 3.5 (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.

(d) (1) If the office determines that a health care entity is not compliant with an approved performance improvement plan and does not meet the cost target, the director may assess administrative penalties commensurate with the failure of the health care entity to meet the target. An entity that has fully complied with an approved performance improvement plan by the deadline established by the office shall not be assessed administrative penalties. However, the director may require a modification to the performance improvement plan until the cost target is met.

(2) The administrative 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 performance improvement plans, the health care entity is repeatedly noncompliant with the performance improvement plan and exceeds the cost target, the director may assess escalating administrative penalties that exceed the penalties imposed under paragraphs (1) and (2).

(4) The board shall consider all of the following, and shall approve the range of penalties and the factors to determine the penalty:

(A) The nature, number, and gravity of the offenses.

(B) The fiscal condition of the health care entity, including revenues, reserves, profits, and assets of the entity, as well as any affiliates, subsidiaries, or other entities that control, govern, or are financially responsible for the entity or are subject to the control, governance, or financial control of the entity.

(C) The market impact of the entity.

(e) Administrative penalties shall not constitute expenditures for the purpose of meeting cost targets. The imposition of administrative 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.

(f) (1) For payers, the director also shall enforce cost targets established by Section 127502 against the cost growth for the net cost of health coverage.

(2) If a payer exceeds the target for per capita growth in 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.

(3) This subdivision does not relieve a payer of its obligation to meet targets for per capita growth in total health care expenditures established by Section 127502, and does not limit enforcement actions for payers under this section.

(g) If data indicate adverse impacts on cost, access, quality, equity, or workforce stability from consolidation, market power, or other market failures, the director may, at any point, require that a cost and market impact review be performed on a health care entity, consistent with Section 127507.2.

(h) (1) The director may directly assess administrative penalties when a health care entity has failed to comply with this chapter by doing any of the following:

(A) Willfully failing to report complete and accurate data.

(B) Repeatedly neglecting to file a performance improvement plan with the office.

(C) Repeatedly failing to file an acceptable performance improvement plan with the office.

(D) Repeatedly failing to implement the performance improvement plan.

(E) Knowingly failing to provide information required by this section to the office.

(F) Knowingly falsifying information required by this section.

(2) The director shall refer a payer who has failed to comply with this chapter, as specified in paragraph (1), to the respective regulator. Failure to comply with enforcement procedures shall constitute a violation of the licensing law applicable to the payer and subject to all civil, administrative, and equitable, but not criminal, remedies.

(3) The director may call a public meeting to notify 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.

(i) The office may establish requirements for health care entities to file for a waiver of enforcement actions due to reasonable factors outside the entity's control, such as changes in state or federal law or anticipated costs for investments and initiatives to minimize future costly care, such as increasing access to primary and preventive services, or under extraordinary circumstances, such as an act of God or catastrophic event. The entity shall submit documentation or supporting evidence of the reasonable factors, anticipated costs, or extraordinary circumstances. The office shall request further information, as needed, in order to approve or deny an application for a waiver.

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

(k) Following an administrative hearing, a health care entity adversely affected by a final order imposing an administrative penalty authorized by this chapter may seek independent judicial review by filing a petition for a writ of mandate in accordance with Section 1094.5 of the Code of Civil Procedure.

(*l*) After an order imposing an administrative penalty becomes final, and if a petition for a writ of mandate has not been filed within the time limits prescribed in Section 11523 of the Government Code, the office may apply to the clerk of the appropriate court for a judgment in the amount of the administrative penalty. The application, which shall include a certified copy of the final order of the administrative hearing officer, shall constitute a sufficient showing to warrant the issuance of the judgment. The court clerk shall enter the judgment immediately in conformity with the application. The judgment so entered has the same force and effect as, and is subject to all the provisions of law relating to, a judgment in a civil action, and may be enforced in the same manner as any other judgment of the court in which it is entered.

Article 4. Quality and Equity Performance

127503. (a) (1) The office shall adopt a single set of standard measures for assessing health care quality and equity across health care service plans, health insurers, hospitals, and physician organizations. Performance on quality and health equity measures shall be included in the annual report required in Section 127501.6.

(2) The standard quality and equity measures 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 and equity measures shall reflect the diversity of California in terms of race, ethnicity, sex, age, language, sexual orientation, gender identity, and disability status. The standard quality and equity measures shall be appropriate for a population under 65 years of age, including children and adults.

(4) The standard quality and equity measures shall consider available means for reliable measurement of disparities in health care, including race, ethnicity, sex, age, language, sexual orientation, gender identity, and disability status.

(5) The office shall reduce administrative burden by selecting quality and equity measures that simplify reporting and align performance measurement with other payers, programs, and state agencies, including leveraging existing voluntary and required reporting, such as the National Quality Forum clinical quality composite measures, to the greatest extent possible. The office shall further reduce administrative burden by encouraging all payers and programs to use the same reporting mechanisms.

(6) Public reporting developed pursuant to this article shall consider differences among health care service plans, health insurers, hospitals, and physician organizations, including factors such as plan or network design or line of business, provider payer mix, and the risk mix associated with the covered lives or patient population for which they are primarily responsible.

(b) In implementing this section, the office shall coordinate with the Department of Managed Health Care to align with requirements under Article 11.9 (commencing with Section 1399.870) of Chapter 2.2 of Division 2 and shall consult with state departments, external quality improvement organizations and forums, payers, physicians, other providers, and consumer advocates or stakeholders with expertise in quality or equity measurement.

(c) The office shall annually review and update the priority set of standard measures for assessing the quality and equity of care pursuant to subdivision (a).

Article 5. Alternative Payment Models

127504. (a) The office shall promote the shift from payments based on fee-for-service to those rewarding equitable high-quality and cost-efficient care. In furtherance of this goal, the office shall convene payers and organize an alternative payment model working group, set statewide goals for the adoption of alternative payment models, and measure the state's progress toward those goals. With input from the working group, the office shall set benchmarks that include, but are not limited to, increasing the percentage of total health care expenditures delivered through alternate payment models or the percentage of membership covered by an alternative payment model.

(b) (1) To advance statewide goals for adoption of alternative payment models, the office shall work with the working group to develop standards for alternative payment models that may be used during contracting between providers and payers. The office shall adopt the standards for alternative payment models on or before July 1, 2024.

(2) The standards for alternative payment models shall focus on encouraging and facilitating multipayer participation and alignment, 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 quality-based 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. The standards shall be consistent, and align, to the extent possible, with the quality and equity measures outlined in Article 4 (commencing with Section 127503) to encourage physicians and other providers to make investments and aim to see year-over-year improvement.

(4) The standards shall address appropriate incentives to physicians and other providers and balanced measures, including, but not limited to, total cost of care and quality, access, and equity requirements and shared savings models, to protect against perverse incentives and unintended consequences.

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

(6) The office shall review the standards at least every five years or more frequently, as appropriate, in order to determine whether the standards are rewarding high-quality, cost-efficient, and equitable care.

(c) The office shall include an analysis of alternative payment model adoption in the annual report required in Section 127501.6.

(d) In implementing this section, the office shall consult with state and federal departments to ensure consistency with state and federal laws, and shall also consult with external organizations promoting alternative payment models and other entities

and individuals with expertise in health care financing and quality and equity measurements.

Article 6. Primary Care and Behavioral Health Investments

127505. (a) (1) The office shall measure and promote a sustained systemwide investment in primary care and behavioral health. In furtherance of this goal, the office shall measure the percentage of total health care expenditures allocated to primary care and behavioral health and set spending benchmarks. Spending benchmarks for primary care shall consider current and historic underfunding of primary care services.

(2) The intent of the spending benchmarks is to build and sustain infrastructure and capacity, specifically methods of reimbursement that shift greater health care resources and investments away from specialty care and toward supporting and facilitating innovation and care improvement in primary care and behavioral health. It is intended that increased support for primary care and behavioral health will not increase costs to consumers or increase the total costs of health care. However, shifting resources may take time and not be associated with immediate savings.

(3) Benchmarks and public reporting developed pursuant to this article shall consider differences among payers, including factors such as plan or network design or line of business, the diversity of settings and facilities through which primary care can be delivered, including clinical and nonclinical settings, the use of both claims-based and non-claims-based payments, and the risk mix associated with the covered lives or patient population for which they are primarily responsible.

(4) In addition to measuring performance of health care entities with the spending benchmarks, the office shall promote improved outcomes for primary care and behavioral health, including, but not limited to, health care entities making investments in, or adopting models that do, any or all of the following:

(A) Promote the importance of primary care and adopt practices that give consumers a regular source of primary care.

(B) Increase access to advanced primary care models and adoption of measures that demonstrate their success in improving quality and outcomes.

(C) Integrate primary care and behavioral health services, including screenings for behavioral health conditions in primary care settings or delivery of behavioral health support for common behavioral health conditions, such as anxiety, depression, or substance use disorders.

(D) Leverage alternative payment models that provide resources at the practice level to enable improved access and team-based approaches for care coordination, patient engagement, quality, and population health. Team-based approaches support the sharing of accountability for delivery of care between physicians and nurse practitioners, physician assistants, medical assistants, nurses and nurse case managers, social workers, pharmacists, and traditional and nontraditional primary and behavioral health care providers, such as peer support specialists, community health works, and others.

(E) Deliver higher value primary care and behavioral health services with an aim toward reducing disparities.

(F) Leverage telehealth and other digital health solutions to expand access to primary care and behavioral health services, care coordination, and care management.

(G) Implement innovative approaches that integrate primary care and behavioral health with broader social and public health services.

(b) The office shall include an analysis of primary care and behavioral health spending and growth, and relevant quality and equity performance measures, in the annual report required pursuant to Section 127501.6.

(c) In implementing this section, the office shall consult with state departments, external organizations promoting investment in primary care and behavioral health, and other entities and individuals with expertise in primary care, behavioral health, and health equity.

Article 7. Health Care Workforce Stability

127506. (a) The intent of this section is to monitor the effects of cost targets on health care workforce stability, high-quality jobs, and training needs of health care workers, in addition to adjustments to cost targets pertaining to nonsupervisory employee labor costs pursuant to paragraph (7) of subdivision (c) of Section 127502. The Legislature intends that the office use a transparent process that allows for public input to monitor how health care entities achieve the cost targets and highlight best practices and discourage practices harmful to workers and patients.

(b) The office shall monitor health care costs while promoting health care workforce stability, including the competitive wages and benefits of frontline health care workers, and the professional judgment of health professionals acting within their scope of practice. The office shall monitor health care workforce stability with the goal that workforce shortages do not undermine health care affordability, access, quality, equity, and culturally and linguistically competent care. The office shall also promote the goal of health care affordability, while recognizing the need to maintain and increase the supply of trained health care 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 health care workforce shortages, the office, on or before July 2024, in consultation with the board and with input from organized labor representing health care workers and other entities and individuals with expertise in the health care workforce, shall develop standards to advance the stability of the health care workforce. The standards may be considered in the setting of cost targets pursuant to Section 127502 or in the approval of performance improvement plans imposed pursuant to Section 127502.5.

Article 8. Health Care Market Trends

127507. (a) The office shall monitor cost trends, including conducting research and studies on the health care market, including, but not limited to, the impact of consolidation, market power, venture capital activity, profit margins, and other market failures on competition, prices, access, quality, and equity. In a manner supportive of the efforts of the Attorney General, the Department of Managed Health Care, and the Department of Insurance, as appropriate, the office shall promote competitive health care markets by examining mergers, acquisitions, corporate affiliations, or other transactions that entail a material change to ownership, operations, or governance structure involving health care service plans, health insurers, hospitals or hospital

systems, physician organizations, pharmacy benefit managers, and other health care entities. The office shall prospectively analyze those transactions likely to have significant effects, seek input from the parties and the public, and report on the anticipated impacts to the health care market. The role of the office is to collect and report information that is informative to the public.

(b) This article does not apply to an exempted provider unless that provider is being acquired by, or affiliating with, an entity that is not an exempted provider. If an entity that is not an exempted provider is acquiring or affiliating with an exempted provider, the entity that is not an exempted provider shall meet the requirements of this article.

(c) (1) A health care entity shall provide the office with written notice of agreements or transactions that will occur on or after April 1, 2024, that do either of the following:

(A) Sell, transfer, lease, exchange, option, encumber, convey, or otherwise dispose of a material amount of its assets to one or more entities.

(B) Transfer control, responsibility, or governance of a material amount of the assets or operations of the health care entity to one or more entities.

(2) Written notice pursuant to paragraph (1) shall be provided to the office at least 90 days prior to entering into the agreement or transaction. If the conditions in paragraph (1) of subdivision (a) of Section 127507.2 apply, the office shall make the notice of material change publicly available, including all information and materials submitted to the office for review with regard to the material change.

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

(d) The requirement to provide notice of a material change pursuant to subdivision (c) does not apply to any of the following:

(1) Agreements or transactions involving health care service plans that are subject to review by the Director of the Department of Managed Health Care for cost impact or market consolidation under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2).

(2) Agreements or transaction involving health insurers that are subject to review by the Insurance Commissioner under Article 14 (commencing with Section 1091) of Chapter 1 of Part 2, of Division 1 of the Insurance Code.

(3) Agreements or transactions involving health care entities under the control of, and operated by, a political subdivision.

(4) Agreements or transactions involving nonprofit corporations that are subject to review by the Attorney General under Article 2 (commencing with Section 5914) of Chapter 9 of Part 2, Division 2 of Title 1 of the Corporations Code.

(e) Agreements or transactions exempted under subdivision (d) from the requirement to provide a notice of material change may be referred to the office for a cost and market impact review by the reviewing authority.

(f) This section does not 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 or the Attorney General's review of any health care agreement or transaction under any state or federal law.

(g) The corporate practice of medicine doctrine prohibiting the practice of medicine or control of medicine, medical corporations, medical partnerships, or physician practices by entities or individuals other than licensed physicians and surgeons shall not be narrowed, abrogated, or otherwise altered by this article.

127507.2. (a) (1) If the office finds that a material change noticed pursuant to Section 127507 is likely to have a risk of a significant impact on market competitions, the state's ability to meet cost targets, or costs for purchasers and consumers, the office shall conduct a cost and market impact review that examines factors relating to a health care entity's business and its relative market position, including, but not limited to, changes in size and market share in a given service or geographic region, prices for services compared to other providers for the same services, quality, equity, cost, access, or any other factors the office determines to be in the public interest. The office also may conduct cost and market impact reviews on any health care entity based on a determination by the director under subdivision (e) of Section 127502.5, or in association with agreements or transactions referred to the office by a reviewing authority listed in paragraphs (1) to (4), inclusive, of subdivision (c) of Section 127507. An agreement or transaction for which a cost and market impact review proceeds under this section shall not be implemented without a written waiver from the office or until 30 days after the office issues a final report.

(2) In conducting the review, the office shall consider the benefits of the material change to consumers of health care services, where those benefits could not be achieved without that transaction, including, but not limited to, increased access to health care services, higher quality, and more efficient health care services where consumers of health care services benefit directly from those efficiencies. The party subject to the review may provide information demonstrating the benefits of the material change or information demonstrating the benefits of an integrated organization where the material change would increase those benefits, and where the benefits involve cost, quality, or access to care for consumers of health care services.

(3) Within 60 days of receipt of a notice of material change, the office shall either advise the noticing health care entity of the office's determination to conduct a cost and market impact review or provide a waiver or conditional waiver. The health care entity shall have 30 days to object to a conditional waiver in writing, and the office shall proceed with a cost and market impact review upon receipt of a written objection.

(4) In furtherance of this article, the office shall conduct investigations, including, but not limited to, compelling, by subpoena, health care entities and other relevant market participants to submit data and documents.

(5) 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 and the public to respond in writing to the findings in the preliminary report, the office shall issue its final report.

(b) 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, the public, and other relevant market participants, and relevant timelines.

(c) (1) The office and the board shall keep confidential all nonpublic information and documents obtained under this article that were not required with the notice of material change or from the parties to the transaction, and shall not disclose the

confidential information or documents to any person, other than the Attorney General, without the consent of the source of the information or documents, except in a preliminary report or final report under this section if the office believes that disclosure should be made in the public interest after taking into account any privacy, trade secret, or anticompetitive considerations. Prior to disclosure in a report, the office shall notify the relevant party and provide the source of nonpublic information an opportunity to specify facts documenting why release of the information is damaging or prejudicial to the source of the information and why the public interest is served in withholding the information. Information that is otherwise publicly available, or that has not been confidentially maintained by the source, shall not be considered nonpublic.

(2) Notwithstanding any other law, all nonpublic information and documents obtained under this article shall not be required to be disclosed pursuant to the California Public Records Act (Chapter 3.5 (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.

(d) (1) The office may refer its findings, including the totality of documents gathered and data analysis performed, to the Attorney General for further review of any unfair methods of competition, anticompetitive behavior, or anticompetitive effects.

(2) This section does not limit the authority of the Attorney General to protect consumers in the health care market or to protect the economy of the state, or any significant part thereof, insofar as health care is concerned, under any state or federal law. The authority of the Attorney General to maintain competitive markets and prosecute state and federal antitrust and unfair competition violations shall not be narrowed, abrogated, or otherwise altered by this section.

127507.4. In furtherance of this article, the office may do all of the following:

(a) Contract with, consult, and receive advice from any state agency on terms and conditions that the office deems appropriate.

(b) Contract with experts or consultants to assist in reviewing a proposed agreement or transaction.

(1) Contract costs shall not exceed an amount that is reasonable and necessary to conduct the review and complete the report.

(2) The office shall be entitled to reimbursement from the health care entity subject to review for all actual, reasonable, and direct costs incurred in reviewing, evaluating, and making the determination referred to in Section 127507.2, including administrative costs. The health care entity subject to review shall promptly pay the office, upon request, for all of those costs.

127507.6. In addition to any legal remedies, the office shall be entitled to specific performance, injunctive relief, and other equitable remedies a court deems appropriate for enforcement of any of the requirements of this article and shall be entitled to recover its attorney's fees and costs incurred in remedying each violation.

SEC. 3. Section 10181.35 is added to the Insurance Code, to read:

10181.35. (a) It is the intent of the Legislature in enacting this section to ensure that insureds benefit from reductions in the rate of growth in health care costs as a result of the establishment of the Office of Health Care Affordability.

(b) In submitting rates for review consistent with this article, a health insurer shall demonstrate the impact of any changes in the rate of growth in health care costs

resulting from the health care cost targets set pursuant to Chapter 2.6 (commencing with Section 127500) of Part 2 of Division 107 of the Health and Safety Code.

(c) In determining whether a rate is unreasonable or not justified, the commissioner shall consider the impact on changes in health care costs as a result of the health care cost targets set pursuant to Chapter 2.6 (commencing with Section 127500) of Part 2 of Division 107 of the Health and Safety Code.

SEC. 4. The Legislature finds and declares that Section 2 of this act, which adds Chapter 2.6 (commencing with Section 127500) to Part 2 of Division 107 of the Health and Safety Code, imposes limitations 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:

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

SEC. 5. The provisions of this measure are severable. If any provision of this measure or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

SEC. 6. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

LEGISLATIVE COUNSEL'S DIGEST

Bill No.
as introduced, _____.
General Subject: California Health Care Quality and Affordability Act.

Existing law generally requires the State Department of Public Health to license, inspect, and regulate health facilities, including hospitals. Existing law requires health facilities to meet specified cost and disclosure requirements, including maintaining an understandable written policy regarding discount payments and charity.

Existing law establishes the Department of Health Care Access and Information (HCAI) to oversee various aspects of the health care market, including oversight of hospital facilities and community benefit plans.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Violation of the Knox-Keene Act is a misdemeanor. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires each department to develop and adopt regulations to ensure that enrollees and insureds have access to needed health care services in a timely manner. Existing law requires that health care service plans and health insurers submit rates to their regulating entity for review.

This bill would establish, within HCAI, the Office of Health Care Affordability to analyze the health care market for cost trends and drivers of spending, develop data-informed policies for lowering health care costs for consumers and purchasers, set and enforce cost targets, and create a state strategy for controlling the cost of health care and ensuring affordability for consumers and purchasers. The bill would also establish the Health Care Affordability Board, composed of 8 members, appointed as prescribed.

The bill would require the board to establish statewide health care cost targets for per capita total health care expenditures by the 2025 calendar year and specific targets for each health care sector, including fully integrated delivery system sector and geographic region, and for an individual health care entity, as appropriate, by the 2028 calendar year. The bill, commencing in 2026, would require the office to take progressive actions against health care entities for failing to meet the cost targets, including performance improvement plans and escalating administrative penalties. The bill would establish the Health Care Affordability Fund for the purpose of receiving and, upon appropriation by the Legislature, expending revenues collected pursuant to the provisions of the bill.

The bill would require the office to set standards for various health care metrics, including health care quality and equity, alternative payment models, primary care and behavioral health investments, and health care workforce stability. The bill would require the office to gather data and present a report on baseline health care spending trends and underlying factors on or before June 1, 2025. On or before June 1, 2026, the bill would require the office to prepare and publish annual reports concerning health

care spending trends and underlying factors, along with policy recommendations to control costs and the other stated metrics. The bill would require the Director of the Department of Health Care Access and Information to call for public statements on findings of the annual report and to solicit and collect comments from the public and purchasers, as specified.

The bill would require the office to monitor cost trends in the health care market and to examine health care mergers, acquisitions, corporate affiliations, or other transactions that entail material changes to ownership, operations, or governance of health care service plans, insurers, hospitals or hospital systems, physician organizations, pharmacy benefit managers, and other health care entities. The bill would require the health care entities to provide the office with written notice, as specified, of agreements and transactions that would sell, transfer, lease, exchange, option, encumber, convey, or otherwise dispose of a material amount of assets, or that would transfer control, responsibility, or governance of a material amount of the assets or operations to one or more entities. The bill would require the office to conduct a cost and market impact review, as specified, if it finds that the change is likely to have a risk of a significant impact on market competition, the state's ability to meet cost targets, or costs for purchasers and consumers. The bill would prohibit an agreement or transaction for which a cost and market impact review proceeds to be implemented without a written waiver from the office or until 30 days after the office issues its final report. The bill would require the health care entity to pay specified costs associated with that review and completing the report.

The bill would require health care service plans and health insurers, in submitting rates for review, to demonstrate the impact of any changes in the rate of growth of health care costs resulting from the health care cost targets. By creating a new crime under the Knox-Keene Act, this bill would impose a state-mandated local program.

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.

This bill would declare that its provisions are severable.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

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