California Health Care Quality and Affordability Act (AB 1130) Passes Assembly, On Path to Creating Healthcare Cost Commission in California

In February of this legislative session, California Assemblymember Jim Wood introduced AB 1130, titled the California Health Care Quality and Affordability Act. Wood was prompted to draft AB 1130 when a 2020 California Health Care Foundation poll found that 84% of Californians surveyed cited health care affordability as an extremely or very important issue to them.[1] The bill would establish the Office of Healthcare Affordability (the "office") within the Office of Statewide Health Planning and Development (OSHPD) and be tasked with analyzing health care markets for cost trends and drivers of spending, developing data-informed policies for lowering health care costs for consumers, setting and enforcing cost targets, and creating a state strategy for controlling the cost of health care and ensuring affordability for consumers and purchasers. The bill has several articles, all of which have the purpose of controlling health care costs while ensuring high quality of healthcare in California.

In this post, we break down the articles of the California Health Care Quality and Affordability Act as they pertain to healthcare price and competition and analyze how the proposed office compares with some of the other state healthcare cost commissions.

Office of Health Care Affordability

The first part of AB 1130 creates and lays out the role and functions of the Office of Health Care Affordability. Governor Gavin Newsom proposed creating this office,

which “will be charged with increasing price and quality transparency, developing specific strategies and cost targets for the different sectors of the health care industry, and financial consequences for entities that fail to meet these targets.”[2]

The tasks of the Office of Health Care Affordability include, among other things, increasing cost transparency by publicly reporting total health care spending and the factors contributing to health care cost growth, establishing health care cost targets and setting specific targets by health care sector, promoting the adoption of alternative payment models and investment in primary care and behavioral health, and addressing consolidation, market power, and other market failures through cost and market impact reviews of mergers, acquisitions, or corporate affiliations.

Payers[3] must submit data and other information necessary to allow the office to measure total and per capita health care expenditures, determine whether health care entities met health care cost targets, identify the annual change in health care costs, approve and monitor implementation of corrective action plans, and assess performance on quality and equity measures. Payers are required to submit data on total health care expenditures for each calendar year on or before the end of the following calendar year.

The office is then required to publish an annual report concerning health care spending trends and underlying factors, which will contain policy recommendations to control costs and improve quality performance and equity of the health care system. Specifically, the annual report is required to contain total and per capita health care expenditures including consumer out-of-pocket spending, the state’s progress towards achieving health care cost targets, the main drivers and factors of overall cost growth, corrective plans issued and administrative penalties imposed, and a summary of best practices for improving affordability while maintaining access and quality.

Health Care Cost Targets

One of the main goals of AB 1130 is to create and achieve health care cost targets for California. The bill requires the Director of OSPHD (the “director”) to establish

statewide health care cost targets[4] for total health care expenditures and by health care sector. The target will be based on the health care cost target recommendation from the Health Care Affordability Advisory Board (the "advisory board"). The director will establish a methodology to set health care cost targets by reviewing historical trends for economic indicators, costs for Medi-Cal, Medicare, and commercial health care coverage, with the goal of achieving a predictable and sustainable rate of change in total and per capita health care expenditures.

The statewide health care cost target begins with the 2024 calendar year, with enforcement of compliance to begin for targets established for 2025 and each year thereafter. The bill allows for progressive enforcement actions against violating entities in a manner that both ensures compliance with the targets and allows opportunities for remediation. Administrative penalties would be assessed in amounts initially commensurate with the failure to meet the targets, and in escalating amounts for repeated or continuing failure to meet the targets.

Alternative Payment Models and Primary Care & Behavioral Health Investments

Another role of the office is to promote the shift from fee-for-service provider payments to those rewarding equitable high-quality and cost-efficient care. On or before July 1, 2023, the office is required to adopt standards for alternative payment models that may be used by providers and payers when contracting. The bill requires the office to consider the current best evidence for strategies such as investments in primary care and behavioral health, shared risk arrangements, or population-based payments. Standards will be reviewed at least every five years to determine whether they are rewarding high-quality, cost-efficient, and equitable care. The office is also required to set benchmarks that increase the percentage of total health care expenditures delivered through alternate payment models.

As further extension of the push for value-based reform, AB 1130 also requires the office to promote a systemwide investment in primary care and behavioral health. Under the proposal, the office would measure the percentage of total health care expenditures allocated to primary care and set spending benchmarks without

increasing the total costs of care. Additionally, the bill aims to improve outcomes for primary care and behavioral health by promoting entities that would integrate primary care and behavioral health, deliver higher value primary care and behavioral health services, and leverage alternative payment models and telehealth to improve access to care.

An analysis of the alternative payment model adoption as well as primary care and behavioral health spending and growth will also be included in the annual report.

Health Care Market Trends

Abundant research has shown that market consolidation and lack of competition is a driving force behind increases in healthcare costs. AB 1130 targets this issue in the last article of the bill by giving the office the role of monitoring cost trends on the health care market by taking into consideration the impact of consolidation, market power, venture capital activity, and other market failures on competition, prices, access, quality, and equity.

In order to promote competition in the healthcare market, the office is required to examine mergers, acquisitions, corporate affiliations, or other transactions that entail a material change to ownership, operations, or governance structure involving a wide range of health care entities, including health care service plans, health insurers, hospitals or hospital systems, physician organizations, and pharmacy benefit managers. These examinations would occur in collaboration with the Attorney General, the Department of Managed Health Care, and the Department of Insurance.

Specifically, the bill requires a health care entity provide the office with written notice of agreements or transactions, at least 90 days prior to entering into the agreement or transaction, that do either of the following: 1) sell, transfer, lease, exchange, option, encumber, convey, or otherwise dispose of a material amount of its assets to one or more entities; or 2) transfer control, responsibility or governance of a material amount of the assets or operations of the health care entity to one or more entities.

The office is required to conduct a cost and market impact review if it finds that a material change 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 cost and market impact review must examine factors relating to a health care entity's business and its relative market position, including, but not limited to, 1) changes in size and market share in a given service or geographic region, 2) prices for services compared to other providers for the same services, 3) quality, equity, cost, access, and 4) any other factors the office determines to be in the public interest. When conducting the review, the office should consider benefits of the material change to consumers of health care services, including increased access to health care services, higher quality, or more efficient health care services where consumers of health care services benefit directly from those efficiencies. The entity subject to the review is allowed to provide information demonstrating the benefits of the material change.

Within 60 days of receipt of material change, the office is required to either advise the health care entity of the determination to conduct a cost and market impact review or provide a waiver or conditional waiver. The office may refer its findings to the attorney general for further review of any unfair methods of competition, anticompetitive behavior or anticompetitive effects.

Comparison with Other State Healthcare Cost Commissions

If enacted, California will join at least four other states that have already established healthcare cost commissions, including Maryland, Massachusetts, Oregon, and Rhode Island. Similar to California, all four states implemented a cost commission with the goal of making health care in their state more affordable for consumers. Each state's commission operates differently in terms of structure and scope but use similar methods to collect healthcare spending data.

In terms of structure and makeup, some of the state cost commissions are established within the Office of the Insurance Commissioner, for example Rhode Island, while other commissions, like in Massachusetts, are independent agencies made up entirely of health care experts and consumers.[5] California's Office of

Health Care Affordability, as proposed, will be established within the Office of Statewide Health Planning and Development (OSHPD), a special state entity tasked with collecting and disseminating data and other information about California's healthcare infrastructure. The majority of the duties will be assigned to the Director of OSHPD, who will be informed by an advisory board regarding health care cost targets.

While other states limit their cost review to only specific sectors of their healthcare markets, the scope of California's Office of Healthcare Affordability is most similar to Massachusetts' Health Policy Commission, which covers total health care expenditures while also setting specific targets for each health care sector.[6] Additionally, California will require entities that exceed their cost target to submit and implement a corrective action plan, similar to the improvement plans required in Massachusetts.[7] California's Office of Healthcare Affordability will also follow Massachusetts' model to analyze changes in market structure, including mergers and consolidations, and can bring matters to the state's attorney general for action.

Each of the four states have an active all-payers claims database (APCD) that is an important data source for the cost commission in each state. With the recent enactment and planned implementation of California's ACPD, the Health Care Payments Data Program (see Source Blog post), California can similarly use its ACPD to calculate total health care expenditures, with the intent of minimizing reporting burdens for payers and providers.[8]

After three amendments, the Assembly passed AB 1130 on June 3 and the bill moved to the Senate where it was referred to the Committee on Health and Judiciary as of June 16. The Senate has until September 10 to vote on the bill. If it passes the Senate, Governor Newsom would have until October 10 to sign the bill into law or veto it.

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[1] *Asm. Jim Wood Introduces Priority Health Care Package*, Assemblymember Jim Wood District 2 (February 19, 2021) https://a02.asmdc.org/press-releases/20210219-asm-jim-wood-introduces-priority-health-care-package.

[2] Health Access, *The Office of Health Care Affordability*, at 1 https://health-access.org/wp-content/uploads/2020/03/Office-of-Health-Care-Affordability-Fact-Sheet_final_2.18.19.pdf.

[3] "Payer" means private and public health care payers, including: a health care service plan, a health insurer licensed to provide health insurance, a publicly funded health care program, including Medi-Cal and Medicare, a third-party administrator, any other public or private entity, other than an individual, that pays or reimburses for any part of the cost for the provision of health care.

[4] Health care cost target means the target percentage for the annual increase in total and per capita health care expenditures in the state.

[5] *Id*. at 14.

[6] Glenn Melnick & Susan Maerki, *Commissioning Change: How Four States Use Advisory Boards to Contain Health Spending*, Cal. Health Care Found., Jan. 2020, at 12, 13.

[7] *Id*. at 8.

[8] See more about California's Health Care Payments Data Program here.