CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

May 27, 2021

The Honorable Jim Wood
Chair, Assembly Health Committee
State Capitol, Room 6005
Sacramento, CA 95814

SUBJECT: AB 1130 (Wood) – Oppose unless Amended

Dear Assembly Member Wood:

The California Hospital Association (CHA) welcomes the opportunity to continue discussions on AB 1130, the California Health Care Quality and Affordability Act, which has been described as the most progressive and aggressive proposal to limit health care spending in the nation. We appreciate the extensive work to date with you, your staff, and the Administration. However, key concerns previously raised about this proposal, outlined below, remain, as does for now our position of oppose unless amended.

We previously provided a longer list of several proposed amendments that would improve the success of this proposal to make health care more affordable in California. At your request, we have narrowed that list to three critical changes that we urge you to please reconsider.

In addition to the three changes below, there are important conforming amendments necessary if the bill is to align with the authors' and Administration's stated intent. These amendments clarify that the intent of the bill is to reduce the rate of growth in California's health care spending, not to cut spending; and, in setting a statewide health care cost target, that total health care expenditures should be calculated on a per capita, risk-adjusted basis. Why are these technical-sounding per capita and risk adjustments so important? Because California's population is both increasing (expected to exceed 44 million by 2030) and aging at a fast pace. If the statewide health care cost target is not first adjusted to accommodate our growing and aging population, the proposal to cap spending would force California to spend less and less per person on health care just to accommodate the fact that we will have more people in the state over time and that the health needs of California's seniors are greater. Therefore, these changes are critical to the success of the proposal over time.

Because of the pressing need to address health care affordability in California recognized by you, the Administration, and CHA, we continue to focus on the following critically important changes to this bill to improve the approach. Without them, instead of making health care more affordable, the bill could instead limit Californians' access to health care services, lock in care inequities that exist today, and create

little to no savings for consumers and purchasers. If not structured appropriately, this proposal could limit the amount and quality of care that Californians receive in the state's effort to limit total health care spending, rather than providing to Californians the health care that they need when they need it.

- **Include the cost of health insurance premiums in the Office of Health Care Affordability's definition and calculation of the total cost of health care. Unless the health insurance premiums paid by consumers, employers, and other purchasers are part of that definition and calculation, there is no guarantee that any savings achieved by this bill will be passed on to consumers and purchasers.**

The current bill holds insurance companies accountable only for the rate of increase in their annual profit and administrative costs — not for the total premium they charge consumers, employers, and other purchasers. The Administration has said it will rely on the existing state process, under the Department of Managed Health Care (DMHC) or the California Department of Insurance, for reviewing health insurance premiums. DMHC's review process does not consider the rate of growth when reviewing the premium rate increases. Consider to following rate increases which DMHC found to be "not unreasonable" and one situation where they determined it to be "unreasonable":

- Blue Cross of California (Anthem Blue Cross) finalized rate increases of 8.8% in 2020, 10.0% in 2019, and 37.3% in 2018, all which DMHC found to be "*not unreasonable*."
- Aetna Health of California finalized rate increases of 11.9% in 2016, which DMHC also found to be "*not unreasonable*."
- In 2015, when DMHC found Aetna Health of California's rate increase of 21% to be "unreasonable," the only enforcement action taken was a requirement for Aetna to notify their members in the plan that DMHC found the increase to be unreasonable. Simply put, DMHC did not have the ability to enforce a change or assess a penalty for the premium rate increase it found to be unreasonable.

The purpose of the current state review of insurance premiums is very different from the purpose of AB 1130. The current state review of insurance premium rates is to determine the "reasonableness" of the premium. The purpose of AB 1130 is to cap the annual rate of growth in total health care spending to no more than a specific amount set annually by the state. The cost of health insurance premiums and controlling the annual rate of increase is central to making care more affordable for Californians. If all we do is control how much health care providers are paid in California, there is no guarantee that those savings will translate into lower rates of growth in health insurance premiums for consumers. Given that payers develop premiums that are based on their assumed risk of providing services, payers will be able to protect against and retain some or all the cost savings generated by providers unless the total premium is included in the definition of the total cost of health care. Nothing in this bill connects the two different processes.

In Maryland, a state that has adopted a cap on health care spending per capita and hospital rate setting, the cost savings achieved have not been passed on to consumers. According to a *Vox* analysis of the Maryland system, published in January 2020, "…(t)he Maryland system's most conspicuous failing is that cost savings don't seem to be getting passed on to consumers. Private insurers in Maryland are paying among the lowest rates for health care services because of the rate-setting system. But so far, Maryland's private insurance premiums, both on Obamacare's individual insurance marketplace and for employer-

based insurance, have risen in line with the rest of the nation." According to Katie Wunderlich, executive director of Maryland's Health Services Cost Review Commission, "Our model is generating benefits to private insurance companies, but that doesn't tie directly to the cost of premiums."

The cost of health insurance premiums in California must be added to the definition and calculation of total health spending in this bill. The bill's authors and the Administration have said that they intend to reduce the rate of growth in health spending by focusing on corrective action plans, if needed; they hope that penalties are not needed. The same approach should apply to insurance companies and health insurance premiums in California without concern to insurers if the approach centers, as stated, on collective corrective action.

- **Make the setting of sector-specific targets by the Office optional and permissive, not required. Simply changing the word "shall" to "may" will give the Office the time and data analysis it needs to conduct to understand whether sector-specific targets advance affordability and, if so, how to set them.**

We do not have the information needed to make that determination a priori in statute. Some stakeholders are so diversified as to be difficult to place into a sector. For example, the insurer Cigna purchased a pharmacy benefit management company and is now providing telehealth and behavioral health services. Anthem owns clinics that serve seniors and recently purchased a company that provides care at home for seriously ill patients. CVS provides in-store clinics and is testing virtual primary care. Some health care systems have multiple sectors of service including hospital care, outpatient care, nursing home care and home care. If used, sector-specific targets must be carefully defined and designed, to yield the desired result.

Sectors can have the potential of creating unintended consequences, specifically giving incentives for one sector to shift spending to another sector to avoid triggering the cap, thus discouraging care coordination. Using sector targets may perpetuate the silos. Providers must engage in care coordination across health care sectors to effectively manage disease, rather than within sectors. This coordination has proven to reduce cost by reducing waste and duplication in care delivery. Health care providers should be encouraged, not discouraged, to work with each other to manage care and risk. The bill should be changed to make sectors optional, leaving that decision to the Office.

- **Penalties should be tempered by the impact of any penalty on access, quality, and an entity's financial condition. Penalties should create incentives for entities to follow corrective action plans imposed by the Office, not be so onerous as to jeopardize the existence of an entity or that entity's ability to provide care in a community or provide coverage for Californians.**

Currently, the bill would allow penalties to be an amount up to the entity's spending in excess of the health care spending targets set by the state. If targets are set too tightly or spending proves more difficult to control than anticipated, penalties of this size could threaten an entity's continued existence. Because of

data lags, any penalties assessed will be based on circumstances two to three years prior. Entities can only change their activities moving ahead — coverage already offered cannot be taken back, care already provided cannot be taken back, pay increases already paid cannot be taken back, and contracts cannot be voided. Because of data lags, it may be several years before the data will show whether a corrective action plan has been successful. In the meantime, penalties must be tempered and flexible to ensure entities are not placed at risk of closure or bankruptcy.

Included below are the specific amendments CHA believes will address the principal issues noted above. Please contact me at (916) 812-7406 to further discuss the above comments. We look forward to continuing to work with your office and the administration on this important proposal.

Sincerely,

Kathryn Scott
SVP, State Relations and Advocacy

cc: Liz Snow, Chief of Staff, The Honorable Jim Wood
Rosielyn Pulmano, Principal Consultant, Assembly Health Committee
Joe Shinstock, Consultant, Assembly Republican Caucus
Elizabeth Landsberg, Director, Office of Statewide Health Planning and Development

APPENDIX:

1) **Include the cost of health insurance premiums in the Office of Health Care Affordability's definition and calculation of the total cost of health care. Unless the health insurance premiums paid by consumers, employers and other purchasers are part of that definition and calculation, there is no guarantee that any savings achieved by this bill will be passed on to consumers and purchasers.**
    a. Expand the definition and enforcement for health plans to include *total premiums*, not just administration and profit. Today, DMHC/DOI processes have no enforcement mechanisms, and don't actually stop increases even if they are found to be unreasonable.
        - Section 127500(s)(4) change "The net cost of health coverage" to "**the premiums received by a payer**" (conforming amendment - delete 127500(m)(1) and (2))
        - Section 127502(b)(6) change "shall also apply to the net cost of health coverage" to "**shall apply to the premiums received by a payer**" and strike "to deter growth in administrative costs and profits."
        - Delete section 127502.5(f)(1) and (2)

2) **Make the setting of sector-specific targets by the Office optional and permissive, not required. Simply changing the word "shall" to "may" will give the Office the time to conduct data analyses they need to understand whether sector-specific targets advance affordability and, if so, how to set them.**
    a. As proposed, Section 127502(b)(1) includes "**shall**" which requires the office to establish sector and/or geographic targets without having the ability to evaluate whether that is appropriate. Decisions to implement these requirements should be left to their expertise and not predetermined in the authorizing legislation.
        - Instead of striking all of Section 127502(b) as we previously requested, amend Section 127502(b)(1) to read: "The director ***may*** set specific targets by health care sector and/or geographic region, or any other health care entities as appropriate."
        - Following conforming amendments:
            1. Sections 127502(b)(2) and 127502(f)(2).
            2. Delete both Section 127501(c)(3) and Section 127501.11(a)(2).

3) **Penalties should be tempered by the impact of any penalty on access, quality, and an entity's financial condition. Penalties should create incentives for entities to follow corrective action plans imposed by the Office, not be so onerous as to jeopardize the existence of an entity or that entity's ability to provide care in a community or provide coverage for Californians.**
    a. Add the following to Section 127502.5(c)(4): "In determining the amount of the administrative penalty, the office shall consider the nature and number of offenses **and the impact of the penalty amount on access, quality, and the health care entities financial stability**."

4) **Make requisite amendments in order to achieve the author's and Administration's stated intent with regard to reducing the rate of growth in health spending and setting a statewide health care cost target for total per capita, risk-adjusted health care expenditures.**
    a. Replace "change" with "increase," insert "**per capita**" after "total," and strike," whether negative or positive" in Section 127500.2(h)

b. Insert "**per capita**" after "statewide" in Section 127502(a)(1) and before "cost" in Sections 127502(c), 127502(f)(1)
c. Insert "**per capita**" after "total" in section 127500.5(j)
d. Section 127500.5 (b) change "reduce" to "**reduce the rate of growth in**"
e. Section 127500.5(k)(1) change "lowering" to "**reducing the rate of growth in**"
f. Add in "**risk-adjusted**" before "per capita" in the following sections: 127500.5(j), 127500.5(k)(1), 127501(c)(2), 127501.6(c)(2)(A), 127502(a)(1), 127502(c), 127502(e), and 127502(f)(1)