SENATE RULES COMMITTEE SB 343
Office of Senate Floor Analyses
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THIRD READING

Bill No: SB 343
Author: Pan (D)
Introduced: 2/19/19
Vote: 21

SENATE HEALTH COMMITTEE: 7-1, 4/3/19
AYES: Pan, Durazo, Hurtado, Leyva, Mitchell, Monning, Rubio
NOES: Stone
NO VOTE RECORDED: Grove

SENATE APPROPRIATIONS COMMITTEE: 4-2, 4/22/19
AYES: Portantino, Bradford, Hill, Wieckowski
NOES: Bates, Jones

SUBJECT: Healthcare data disclosure

SOURCE: California State Council of Service Employees International Union

DIGEST: This bill eliminates provisions in health insurance rate filing requirements that permit Kaiser Permanente health plans and insurers to report medical trend assumptions in a different manner than other health plans, including reporting trends in fewer categories, and eliminates provisions in hospital OSHPD (Office of statewide Health Planning and Development) reporting requirements that permit Kaiser Permanente hospitals to report certain data as a group rather than by individual facility, and to not have to report certain financial data.

ANALYSIS:

Existing law:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) and the California Department of Insurance (CDI) to regulate health insurance. [HSC §1340, et seq. and INS §106, et seq.]

2) Requires health plans and health insurers, for the small group and individual markets, to file with DMHC and CDI, at a specified minimum length of time prior to implementing any rate change (generally 120 days prior), specified rate information so that the departments can review the information for unreasonable rate increases. [HSC §1385.03 and INS §10181.3]

3) Requires health plans and health insurers for the large group market, to file with the DMHC and CDI, at least 60 days prior to implementing any rate change, specified rate information related to unreasonable rate increases, including all information that is required by the Affordable Care Act. These provisions have never been implemented. [HSC §1385.07 and INS §10181.4]

4) Requires health plans and health insurers, for the large group market, to file the weighted average rate increases for all large group benefit designs during the 12-month period ending January 1 of the following year. This requirement for large group is different from the rate filings for the small group and individual market described in 1) and 2) above, in that this requirement is not a review prior to the rates taking effect, and this requirement is for a weighted average of rate increases. [HSC §1385.045 and INS §10181.45]

5) Designates OSHPD as the state agency designated to collect health facility data for use by all state agencies, including various financial data reports. [HSC §128730, et seq.]

6) Requires OSHPD to establish specific reporting provisions for health facilities that receive a preponderance of the revenue from associated comprehensive group practice prepayment health care service plans (according to OSHPD, Kaiser Permanente Hospitals are the only facility that meets this definition). Permits these health facilities to be authorized to report costs and revenues in a manner that is consistent with the operating principles of these plans and with generally accepted accounting principles. Requires these health facilities, when operated as units of a coordinated group of health facilities under common management, to be authorized to report as a group rather than as individual institutions, and as a group, to submit consolidated income and expense statements. [HSC §128760]

This bill:

1) Eliminates a provision in the existing individual and small group rate review requirements for health plans that permits a health plan that exclusively contracts with no more than two medical groups in the state (a definition that currently only applies to Kaiser Permanente), rather than being required to

report its annual medical trend factor assumptions and projected trend as specified in its rate filings for all benefits and by aggregate benefit category, to instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories that are, to the maximum extent possible, the same or similar to those used by other plans. Eliminates a similar provision in statute governing large group rate review that has never been implemented.

2) Eliminates provisions in the large group average rate increase disclosure requirements that permit a health plan or health insurer that exclusively contracts with no more than two medical groups in the state (Kaiser), rather than being required to report the overall annual medical trend factor assumptions by benefit category, to instead disclose the amount of its actual trend experience for the prior contract year using benefit categories that are, to the maximum extent possible, the same or similar to those used by other plans and insurers.

3) Eliminates the requirement that OSHPD establish specific reporting provisions for Kaiser Permanente Hospitals, the requirement that Kaiser be permitted to utilize established accounting systems, the requirement that Kaiser be permitted to report as a group rather than as individual institutions, and the requirement that Kaiser be permitted to submit a consolidated income and expense statement.

4) Eliminates other Kaiser-specific provisions in OSHPD hospital reporting requirements, including eliminating Kaiser's exemption from having to report revenues by revenue center, and eliminating the ability of Kaiser to provide the following data on a group basis instead of by individual institution for the required quarterly summary financial and utilization data reports:

   a) Total operating expenses;

   b) Total inpatient gross revenues by payer, including Medicare, Medi-Cal, county indigent program, other third parties, and other payers;

   c) Total outpatient gross revenues by payer;

   d) Deductions from revenue in total and by component, including contractual adjustments, bad debts, charity care, restricted donations and subsidies for indigents, support for clinical teach, teaching allowances, and other deductions;

   e) Total net patient revenues by payer;

f) Other operating revenue; and,

g) Nonoperating revenue net of nonoperating expenses.

Comments

1) *Author's statement.* According to the author, this bill updates current transparency and disclosure requirements for the health care industry to include Kaiser Permanente so that all hospitals and health insurance companies are playing by the same set of rules. Kaiser's status as an integrated system of insurance, hospitals and doctors means the health care giant is allowed to avoid some key disclosure requirements. This special provision in state law has allowed them to not report key insurance and hospital financial information like the rest of the industry. With Kaiser representing one in ten California hospitals and more than 40% of insured Californians with commercial coverage, this information gap means state regulators lack data on a significant portion of the health care market. When Kaiser is required to report the same data as its competitors, regulators can make "apple to apple" comparisons of health care pricing. With health care costs continuing to rise, policymakers, purchasers and consumers should have access to the same information about what is driving cost increases at Kaiser as they have about other hospitals and health insurance companies.

2) *Kaiser reports compared to other health plans and hospitals.* As described in existing law above, Kaiser is permitted to report differently, and provide significantly less data, than other health plans and hospitals. Specifically:

   a) *Health plan/health insurer reporting*. Reviewing a recent rate filing for the small group market for Blue Shield of California, it shows an overall medical trend factor for the HMO product of 4.9%, and the medical trend factor by category, such as 6.4% for physician/other professional services, 10.5% for prescription drugs, 6.4% for hospital outpatient, 3% for laboratory. These are the projected medical trends that form the underlying basis for the proposed rate increase. In the comparable Kaiser small group filing, on the other hand, there is an overall trend factor of 4.6%, and then only two other numbers: 4.5% for hospital inpatient, and 5% for prescription drugs. For all other categories (physician services, laboratory, radiology, hospital outpatient), the filing simply states "see hospital inpatient above." Further, even for the hospital inpatient category where it does provide a trend factor, it is not a forward looking trend expectation, but a retrospective look at the increase in cost it already experienced.

b) *OSHPD reporting*. Hospitals are required to file detailed disclosure reports with OSHPD, including hospital discharge data and emergency care data reports, and with regard to these reports about patient encounters, Kaiser does report similarly to other hospitals. However, hospitals are also required to report financial data, including patient revenue by revenue center (type of service provided by the hospital), statement of assets, liabilities, and net worth, operating expenses and operating margin, salaries and wages, etc. OSHPD is required to establish specific reporting provisions for Kaiser that allows them to report costs and revenues as a group (either Northern California or Southern California) rather than as individual institutions. As a result, a hospital disclosure report for any given Kaiser hospital will be full of blank pages where other hospitals would report various types of expenses and patient revenue.

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: Yes

According to the Senate Appropriations Committee:

- $119,000 (Health Data and Planning Fund) in FY 2020-21, and $107,000 in FY 2021-22 and ongoing, for OSHPD to hire 1.0 Health Program Auditor to conduct a desk audit of the four quarterly financial and utilization reports and the annual financial disclosure report for each of the 33 Kaiser Permanente facilities. OSHPD notes an increase to health facilities' assessment rates, which fund the Health Data and Planning Fund, may be required to implement the bill, but does not yet have a full estimate.

- No fiscal impact to DMHC and CDI.

SUPPORT: (Verified 4/23/19)

California State Council of Service Employees International Union (source)
Alliance of Californians for Community Empowerment
California Conference Board of the Amalgamated Transit Union
California Conference of Machinists
California Labor Federation, Afl-Cio
California Nurses Association/ National Nurses United
California Teamsters Public Affairs Council
Engineers and Scientists of California, Local 20
Health Access California
Los Angeles LGBT Center
Professional & Technical Engineers, Local 21
San Francisco AIDS Foundation

Small Business Majority
The Greenlining Institute
Unite Here International Union, Afl-Cio
Utility Workers Union of America, Local 132
Western Center on Law and Poverty

OPPOSITION: (Verified 4/23/19)

America's Physician Groups
Kaiser Permanente

ARGUMENTS IN SUPPORT: This bill is sponsored by the California State Council of Service Employees International Union (SEIU California), which states that this bill will ensure that union members and employers bargaining for benefits have adequate information to understand the underlying cost drivers behind Kaiser's rates and the degree to which Kaiser hospitals contribute to health care costs. SEIU California states that data from Kaiser is crucial to policymakers' understanding of how California's healthcare markets are functioning. More importantly, SEIU California states that the unlevel playing field afforded to Kaiser puts purchasers at a competitive disadvantage when negotiating insurance rates and gives Kaiser an unfair advantage with its competitors. SEIU California states that the transparency we have now tells a story of prices driving cost increases without any justification on the utilization side. For example, last year alone, Kaiser increased insurance premiums on 4.9 million Californians by 5.2%, and that despite limited detail on the justification for the proposed rate hike, large group insurer rate filings demonstrated that all of Kaiser's rate increases were due to price inflation, not utilization. SEIU California notes that existing laws effectively exempt Kaiser from requirements placed on all other insurers to provide their projected trend factor by benefit category, and that Kaiser alone is allowed to rely an actual experience from the prior benefit year. In practice, this has allowed Kaiser to propose rate increases without demonstrating their underlying assumptions to regulators or purchasers. According to SEIU California, there was a time when Kaiser's integrated delivery model was truly novel, but that many other systems have adopted the integrated delivery system model and that in 2019, it is no longer fair or reasonable to exempt Kaiser from the transparency requirements which apply to all other integrated delivery models, and to all other health plans and hospital systems.

Numerous organizations support this bill and make similar arguments. Western Center on Law and Poverty states in support that not having Kaiser's rate and financial data means that a sizable share of health care cost transparency is missing

in California. Health Access California states in support that it has long supported and sponsored legislation to improve transparency and reporting requirements in the health care industry, and that Kaiser Permanente has been given a different standard, or has been all together exempt from reporting data related to rate review filings and hospital financial reporting.

ARGUMENTS IN OPPOSITION: Kaiser Permanente (KP) states that this bill is unnecessary and will add costs to our system without creating any additional meaningful transparency, and that it is an affront to the integrated model of care. KP states that it is an integrated health care system that is comprised of the non-profit Kaiser Foundation Health Plan, the non-profit Kaiser Foundation Hospitals, and the Permanente Medical Groups. According to KP, because of its unique model, it requested and received language in the two laws that are the subject of this bill so that it could file accurate reports that reflect its underlying operating model. KP states that its filings are not inferior or incomplete, they are simply different, because KP is different. According to KP, it does not build rates and calculate cost trend in the same way as other claims-based systems or capitated systems, and that is hospitals are a singular legal and financial entity. According to KP, this bill would require it to deconstruct our model and establish an entirely new internal structure to look at unit costs for the provision of care, which would be an extremely burdensome and senseless exercise. Regarding the health plan reporting provisions, KP states that this is not a "Kaiser exemption," but simply an acknowledgement that it does not develop trend using the same assumptions and categories as other health plans. KP states that it looks at costs and trend from a "total cost of care" perspective and historical spend. With regard to the hospital reporting provisions, KP states that Kaiser Foundation Hospitals is a singular legal entity that owns and operates 36 hospitals in California, and that each of these hospitals share the same tax ID number. According to KP, it files most of the required information on a facility basis, but it is unable to file financial statements on a facility basis, so the law permits it to properly report in a manner that takes into consideration its model. However, KP states that it values transparency and understands its importance to consumers and policymakers, and that if there is more information it can provide that will yield meaningful transparency and will not be costly to its purchasers, burdensome or contrary to its model, it is happy to explore those options.

America's Physician Groups (APG) states that the flawed position of this bill is that it requires the conformity of the "square peg" of Kaiser's integrated system into the "round hole" of older fee-for-service based data collection and measurement. APG states that this process would require a deconstruction of Kaiser's existing integrated business relationships with its hospitals and physician

groups to create a fictional picture of how the elements of that system relate to other less-integrated contracted "network model" health plan arrangements. According to APG, policy should be driving the transition to a future that requires all health care system players to be publicly measured under an outcome-based transparency model.

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