File No. 190690 Committee Item No. _____
Board Item No. 56

COMMITTEE/BOARD OF SUPERVISORS

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Prepared by: Jocelyn Wong Date: June 14, 2019
Prepared by: _____ Date: _____

FILE NO. 190690 RESOLUTION NO.

[Supporting California State Senate Bill No. 343 (Pan) - Uniform Healthcare Data Disclosure]

Resolution supporting California State Senate Bill No. 343, authored by State Senate Health Committee Chair Richard Pan, to create uniform healthcare data disclosures and parity in data reporting across the healthcare industry, in the expectation that uniform data will more fully inform health insurance purchasing decisions by the City and County of San Francisco and all other purchasers in the City and County.

WHEREAS, California premiums for job-based health insurance have risen 249% since 2002, more than six times the rate of general inflation, which disproportionately impacts the budgets of employers and workers in the private and public sectors, and has most frequently shifted a greater share of cost-sharing onto individual workers; and

WHEREAS, Kaiser Permanente is the State's largest healthcare provider and health insurer, operates a significant percentage of hospitals in California and holds a majority of the large group employer market in California, and is one of the health insurance choices currently offered to employees of the City and County of San Francisco; and

WHEREAS, In California, we have a highly incomplete understanding of healthcare costs because the Kaiser Health Plan and Kaiser hospitals have reporting exceptions in State law which no other health insurers or acute care health providers enjoy; and

WHEREAS, Kaiser Permanente's profits have escalated sharply in recent years, with $6.4 billion in profit in the 2017 and 2018 fiscal years, and $3.2 billion in profit in the first quarter of 2019 alone; and

WHEREAS, These profit escalations cause the public to be reasonably concerned that the health insurance rate increases Kaiser Permanente has been demanding of public and

private sector purchasers of health insurance may not be justified by utilizations and costs of their health care services; and

WHEREAS, According to Health Access "For years, 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, which leaves regulators and policymakers in the dark..."; and

WHEREAS, Small Business Majority, an organization representing over 3.9 million small businesses in California, declares that SB 343 will "...help lower healthcare costs for California's business owners by ensuring employers have access to adequate information about rates and cost drivers behind California's healthcare..."; and

WHEREAS, The Silicon Valley Employers Forum, which represents over 50 high tech employers, explains that "...Having uniformed data disclosure will allow consumers and policymakers to make an "apples to apples" comparison of the true costs of healthcare (to) ensure that purchasers of healthcare, like large employers or union trust funds, have adequate information when choosing to purchase healthcare plans..."; and

WHEREAS, The California Labor Federation, representing more than 1,200 Unions and 2.1 million working Californians, explains in its letter supporting SB 343 that "...Understanding Kaiser's financial status, cost drivers, and other information is critical to understanding and controlling health care costs..."; now, therefore, be it

RESOLVED, That the City and County of San Francisco supports State Senate Bill No. 343, authored by Senator Dr. Richard Pan, which will create parity in data reporting across California's healthcare industry, in the expectation that uniform data reporting will more fully inform health insurance purchasing decisions by the City and County of San Francisco and all other purchasers in the City and County; and, be it

FURTHER RESOLVED, That the City and County of San Francisco will send letters of support for SB 343 to the Assembly Health and future relevant committees and all state legislators representing the City and County of San Francisco, urging the California Legislature to pass SB 343 into law.

SENATE BILL No. 343

Introduced by Senator Pan

February 19, 2019

An act to amend Sections 1385.03, 1385.045, 1385.07, 128735, 128740, and 128760 of the Health and Safety Code, and Section 10181.45 of the Insurance Code, relating to healthcare.

LEGISLATIVE COUNSEL'S DIGEST

SB 343, as introduced, Pan. Healthcare data disclosure.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally requires a health care service plan or health insurer in the individual, small group, or large group markets to file rate information with the appropriate department, but specifies alternative information to be filed by a health care service plan or health insurer that exclusively contracts with no more than 2 medical groups.

Existing law establishes the Office of Statewide Health Planning and Development (OSHPD) in the California Health and Human Services Agency to regulate health planning and research development. Existing law generally requires a healthcare facility to report specified data to OSHPD, but requires OSHPD to establish specific reporting provisions for a health facility that receives a preponderance of its revenue from associated comprehensive group practice prepayment health care service plans. Existing law authorizes hospitals to report specified financial and utilization data to OSHPD, and file cost data reports with OSHPD, on a group basis, and exempts hospitals authorized to report as a group from reporting revenue separately for each revenue center.

This bill would eliminate alternative reporting requirements for a plan or insurer that exclusively contracts with no more than 2 medical groups or a health facility that receives a preponderance of its revenue from associated comprehensive group practice prepayment health care service plans and would instead require those entities to report information consistent with any other health care service plan, health insurer, or health facility, as appropriate. The bill would also eliminate the authorization for hospitals to report specified financial and utilization data to OSHPD, and file cost data reports with OSHPD, on a group basis. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

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.

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

SECTION 1. Section 1385.03 of the Health and Safety Code is amended to read:

1385.03. (a) ~~All~~ *A* health care service ~~plans~~ *plan* shall file with the department all required rate information for grandfathered individual and grandfathered and nongrandfathered small group health care service plan contracts at least 120 days prior to implementing ~~any~~ *a* rate change. ~~All~~ *A* health care service ~~plans~~ *plan* shall file with the department all required rate information for nongrandfathered individual health care service plan contracts on the earlier of the following dates:

(1) One hundred days before October 15 of the preceding policy year.

(2) The date specified in the federal guidance issued pursuant to Section 154.220(b) of Title 45 of the Code of Federal Regulations.

(b) A plan shall disclose to the department all of the following for each individual and small group rate filing:

(1) Company name and contact information.

(2) Number of plan contract forms covered by the filing.
(3) Plan contract form numbers covered by the filing.
(4) Product type, such as a preferred provider organization or health maintenance organization.
(5) Segment type.
(6) Type of plan involved, such as for profit or not for profit.
(7) Whether the products are opened or closed.
(8) Enrollment in each plan contract and rating form.
(9) Enrollee months in each plan contract form.
(10) Annual rate.
(11) Total earned premiums in each plan contract form.
(12) Total incurred claims in each plan contract form.
(13) Average rate increase initially requested.
(14) Review category: initial filing for new product, filing for existing product, or resubmission.
(15) Average rate of increase.
(16) Effective date of rate increase.
(17) Number of subscribers or enrollees affected by each plan contract form.
(18) The plan's overall annual medical trend factor assumptions in each rate filing for all benefits and by aggregate benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology. A plan may provide aggregated additional data that demonstrates or reasonably estimates year-to-year cost increases in specific benefit categories in the geographic regions listed in Sections 1357.512 and 1399.855. ~~A health plan that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the enrollees of the plan shall 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.~~
(19) The amount of the projected trend attributable to the use of services, price inflation, or fees and risk for annual plan contract trends by aggregate benefit category, such as hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology. ~~A health plan that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for~~

~~the enrollees of the plan shall 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.~~

(20) A comparison of claims cost and rate of changes over time.

(21) Any changes in enrollee cost sharing over the prior year associated with the submitted rate filing.

(22) Any changes in enrollee benefits over the prior year associated with the submitted rate filing.

(23) The certification described in subdivision (b) of Section 1385.06.

(24) Any changes in administrative costs.

(25) Any other information required for rate review under ~~PPACA.~~ *the federal Patient Protection and Affordable Care Act (PPACA).*

(c) A health care service plan subject to subdivision (a) shall also disclose the following aggregate data for all rate filings submitted under this section in the individual and small group health *care service* plan markets:

(1) Number and percentage of rate filings reviewed by the following:

(A) Plan year.

(B) Segment type.

(C) Product type.

(D) Number of subscribers.

(E) Number of covered lives affected.

(2) The plan's average rate increase by the following categories:

(A) Plan year.

(B) Segment type.

(C) Product type.

(3) Any cost containment and quality improvement efforts since the plan's last rate filing for the same category of health benefit plan. To the extent possible, the plan shall describe any significant new ~~health care~~ *healthcare* cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period.

(d) The department may require all health care service plans to submit all rate filings to the National Association of Insurance Commissioners' System for Electronic Rate and Form Filing (SERFF). Submission of the required rate filings to SERFF shall

be deemed to be filing with the department for purposes of compliance with this section.

(e) A plan shall submit any other information required under PPACA. A plan shall also submit any other information required pursuant to any regulation adopted by the department to comply with this article.

(f) (1) A plan shall respond to the department's request for any additional information necessary for the department to complete its review of the plan's rate filing for individual and small group health care service plan contracts under this article within five business days of the department's request or as otherwise required by the department.

(2) Except as provided in paragraph (3), the department shall determine whether a plan's rate increase for individual and small group health care service plan contracts is unreasonable or not justified no later than 60 days following receipt of all the information the department requires to makes its determination.

(3) For all nongrandfathered individual health care service plan contracts, the department shall issue a determination that the plan's rate increase is unreasonable or not justified no later than 15 days before October 15 of the preceding policy year. If a health care service plan fails to provide all the information the department requires in order for the department to make its determination, the department may determine that a plan's rate increase is unreasonable or not justified.

(g) If the department determines that a plan's rate increase for individual or small group health care service plan contracts is unreasonable or not justified consistent with this article, the health care service plan shall provide notice of that determination to any individual or small group applicant. The notice provided to an individual applicant shall be consistent with the notice described in subdivision (c) of Section 1389.25. The notice provided to a small group applicant shall be consistent with the notice described in subdivision (c) of Section 1374.21.

(h) For purposes of this section, "policy year" has the same meaning as set forth in subdivision (g) of Section 1399.845.

SEC. 2. Section 1385.045 of the Health and Safety Code is amended to read:

1385.045. (a) For large group health care service plan contracts, ~~each~~ *a* health *care service* plan shall file with the

department the weighted average rate increase for all large group benefit designs during the 12-month period ending January 1 of the following calendar year. The average shall be weighted by the number of enrollees in each large group benefit design in the plan's large group market and adjusted to the most commonly sold large group benefit design by enrollment during the 12-month period. For the purposes of this section, the large group benefit design includes, but is not limited to, benefits such as basic ~~health care~~ *healthcare* services and prescription drugs. The large group benefit design shall not include cost sharing, including, but not limited to, deductibles, copays, and coinsurance.

(b) (1) A plan shall also submit any other information required pursuant to any regulation adopted by the department to comply with this article.

(2) The department shall conduct an annual public meeting regarding large group rates within four months of posting the aggregate information described in this section in order to permit a public discussion of the reasons for the changes in the rates, benefits, and cost sharing in the large group market. The meeting shall be held in either the Los Angeles area or the San Francisco Bay area.

(c) A health care service plan subject to subdivision (a) shall also disclose the following for the aggregate rate information for the large group market submitted under this section:

(1) For rates effective during the 12-month period ending January 1 of the following year, number and percentage of rate changes reviewed by the following:

(A) Plan year.

(B) Segment type, including whether the rate is community rated, in whole or in part.

(C) Product type.

(D) Number of enrollees.

(E) The number of products sold that have materially different benefits, cost sharing, or other elements of benefit design.

(2) For rates effective during the 12-month period ending January 1 of the following year, any factors affecting the base rate, and the actuarial basis for those factors, including all of the following:

(A) Geographic region.

(B) Age, including age rating factors.

(C) Occupation.
(D) Industry.
(E) Health status factors, including, but not limited to, experience and utilization.
(F) Employee, and employee and dependents, including a description of the family composition used.
(G) Enrollees' share of premiums.
(H) Enrollees' cost sharing, including cost sharing for prescription drugs.
(I) Covered benefits in addition to basic ~~health care~~ *healthcare* services, as defined in Section 1345, and other benefits mandated under this article.
(J) Which market segment, if any, is fully experience rated and which market segment, if any, is in part experience rated and in part community rated.
(K) Any other factor that affects the rate that is not otherwise specified.
(3) (A) The plan's overall annual medical trend factor assumptions for all benefits and by aggregate benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology for the applicable 12-month period ending January 1 of the following year. ~~A health plan that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the enrollees of the plan shall instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories, to the maximum extent possible, that are the same as, or similar to, those used by other plans.~~
(B) The amount of the projected trend separately attributable to the use of services, price inflation, and fees and risk for annual plan contract trends by aggregate benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology. ~~A health plan that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the enrollees of the plan shall 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.~~

(C) A comparison of the aggregate per enrollee per month costs and rate of changes over the last five years for each of the following:

(i) Premiums.

(ii) Claims costs, if any.

(iii) Administrative expenses.

(iv) Taxes and fees.

(D) Any changes in enrollee cost sharing over the prior year associated with the submitted rate information, including both of the following:

(i) Actual copays, coinsurance, deductibles, annual out of pocket maximums, and any other cost sharing by the benefit categories determined by the department.

(ii) Any aggregate changes in enrollee cost sharing over the prior years as measured by the weighted average actuarial value, weighted by the number of enrollees.

(E) Any changes in enrollee benefits over the prior year, including a description of benefits added or eliminated, as well as any aggregate changes, as measured as a percentage of the aggregate claims costs, listed by the categories determined by the department.

(F) Any cost containment and quality improvement efforts since the plan's prior year's information pursuant to this section for the same category of health benefit plan. To the extent possible, the plan shall describe any significant new ~~health care~~ *healthcare* cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period.

(G) The number of products covered by the information that incurred the excise tax paid by the health *care service* plan.

(4) (A) For covered prescription generic drugs excluding specialty generic drugs, prescription brand name drugs excluding specialty drugs, and prescription brand name and generic specialty drugs dispensed at a plan pharmacy, network pharmacy, or mail order pharmacy for outpatient use, all of the following shall be disclosed:

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(i) The percentage of the premium attributable to prescription drug costs for the prior year for each category of prescription drugs as defined in this subparagraph.

(ii) The year-over-year increase, as a percentage, in per-member, per-month total health *care service* plan spending for each category of prescription drugs as defined in this subparagraph.

(iii) The year-over-year increase in per-member, per-month costs for drug prices compared to other components of the ~~health care~~ *healthcare* premium.

(iv) The specialty tier formulary list.

(B) The plan shall include the percentage of the premium attributable to prescription drugs administered in a doctor's office that are covered under the medical benefit as separate from the pharmacy benefit, if available.

(C) (i) The plan shall include information on its use of a pharmacy benefit manager, if any, including which components of the prescription drug coverage described in subparagraphs (A) and (B) are managed by the pharmacy benefit manager.

(ii) The plan shall also include the name or names of the pharmacy benefit manager, or managers if the plan uses more than one.

(d) The information required pursuant to this section shall be submitted to the department on or before October 1, 2018, and on or before October 1 annually thereafter. Information submitted pursuant to this section is subject to Section 1385.07.

(e) For the purposes of this section, a "specialty drug" is one that exceeds the threshold for a specialty drug under the Medicare Part D program (Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173)).

SEC. 3. Section 1385.07 of the Health and Safety Code is amended to read:

1385.07. (a) Notwithstanding Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code, all information submitted under this article shall be made publicly available by the department except as provided in subdivision (b).

(b) (1) The contracted rates between a health care service plan and a provider shall be deemed confidential information that shall not be made public by the department and are exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the

Government Code). The contracted rates between a health care service plan and a provider shall not be disclosed by a health care service plan to a large group purchaser that receives information pursuant to Section 1385.10.

(2) The contracted rates between a health care service plan and a large group shall be deemed confidential information that shall not be made public by the department and are exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code). Information provided to a large group purchaser pursuant to Section 1385.10 shall be deemed confidential information that shall not be made public by the department and shall be exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(c) All information submitted to the department under this article shall be submitted electronically in order to facilitate review by the department and the public.

(d) In addition, the department and the health care service plan shall, at a minimum, make the following information readily available to the public on their ~~Internet Web sites,~~ *internet websites* in plain language and in a manner and format specified by the department, except as provided in subdivision (b). For individual and small group health care service plan contracts, the information shall be made public for 120 days prior to the implementation of the rate increase. For large group health care service plan contracts, the information shall be made public for 60 days prior to the implementation of the rate increase. The information shall include:

(1) Justifications for any unreasonable rate increases, including all information and supporting documentation as to why the rate increase is justified.

(2) A plan's overall annual medical trend factor assumptions in each rate filing for all benefits.

(3) A health *care service* plan's actual costs, by aggregate benefit category to include hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology.

(4) The amount of the projected trend attributable to the use of services, price inflation, or fees and risk for annual plan contract trends by aggregate benefit category, such as hospital inpatient,

hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology. ~~A health plan that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the enrollees of the plan shall 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.~~

SEC. 4. Section 128735 of the Health and Safety Code is amended to read:

128735. An organization that operates, conducts, owns, or maintains a health facility, and the officers thereof, shall make and file with the office, at the times as the office shall require, all of the following reports on forms specified by the office that ~~shall be~~ *are* in accord, if applicable, with the systems of accounting and uniform reporting required by this part, except that the reports required pursuant to subdivision (g) shall be limited to hospitals:

(a) A balance sheet detailing the assets, liabilities, and net worth of the health facility at the end of its fiscal year.

(b) A statement of income, expenses, and operating surplus or deficit for the annual fiscal period, and a statement of ancillary utilization and patient census.

(c) A statement detailing patient revenue by payer, including, but not limited to, Medicare, Medi-Cal, and other payers, and revenue ~~center, except that hospitals authorized to report as a group pursuant to subdivision (d) of Section 128760 are not required to report revenue by revenue~~ center.

(d) A statement of cashflows, including, but not limited to, ongoing and new capital expenditures and depreciation.

(e) A statement reporting the information required in subdivisions (a), (b), (c), and (d) for each separately licensed health facility operated, conducted, or maintained by the reporting ~~organization, except those hospitals authorized to report as a group pursuant to subdivision (d) of Section 128760.~~ *organization.*

(f) Data reporting requirements established by the office shall be consistent with national standards, as applicable.

(g) A Hospital Discharge Abstract Data Record that includes all of the following:

(1) Date of birth.

(2) Sex.

(3) Race.
(4) ZIP Code.
(5) Preferred language spoken.
(6) Patient social security number, if it is contained in the patient's medical record.
(7) Prehospital care and resuscitation, if any, including all of the following:
(A) "Do not resuscitate" (DNR) order on admission.
(B) "Do not resuscitate" (DNR) order after admission.
(8) Admission date.
(9) Source of admission.
(10) Type of admission.
(11) Discharge date.
(12) Principal diagnosis and whether the condition was present on admission.
(13) Other diagnoses and whether the conditions were present on admission.
(14) External causes of morbidity and whether present on admission.
(15) Principal procedure and date.
(16) Other procedures and dates.
(17) Total charges.
(18) Disposition of patient.
(19) Expected source of payment.
(20) Elements added pursuant to Section 128738.

(h) It is the intent of the Legislature that the patient's rights of confidentiality shall not be violated in any manner. Patient social security numbers and other data elements that the office believes could be used to determine the identity of an individual patient shall be exempt from the disclosure requirements of the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(i) A person reporting data pursuant to this section shall not be liable for damages in an action based on the use or misuse of patient-identifiable data that has been mailed or otherwise transmitted to the office pursuant to the requirements of subdivision (g).

(j) A hospital shall use coding from the International Classification of Diseases in reporting diagnoses and procedures.

SEC. 5. Section 128740 of the Health and Safety Code is amended to read:

128740. (a) ~~Commencing with the first calendar quarter of 1992, the~~ *The* following summary financial and utilization data shall be reported to the office by ~~each~~ *a* hospital within 45 days of the end of ~~every~~ *a* calendar quarter. Adjusted reports reflecting changes as a result of audited financial statements may be filed within four months of the close of the hospital's fiscal or calendar year. The quarterly summary financial and utilization data shall conform to the uniform description of accounts as contained in the Accounting and Reporting Manual for California Hospitals and shall include all of the following:

(1) Number of licensed beds.

(2) Average number of available beds.

(3) Average number of staffed beds.

(4) Number of discharges.

(5) Number of inpatient days.

(6) Number of outpatient visits.

(7) Total operating expenses.

(8) Total inpatient gross revenues by payer, including Medicare, Medi-Cal, county indigent programs, other third parties, and other payers.

(9) Total outpatient gross revenues by payer, including Medicare, Medi-Cal, county indigent programs, other third parties, and other payers.

(10) Deductions from revenue in total and by component, including the following: Medicare contractual adjustments, Medi-Cal contractual adjustments, and county indigent program contractual adjustments, other contractual adjustments, bad debts, charity care, restricted donations and subsidies for indigents, support for clinical teaching, teaching allowances, and other deductions.

(11) Total capital expenditures.

(12) Total net fixed assets.

(13) Total number of inpatient days, outpatient visits, and discharges by payer, including Medicare, Medi-Cal, county indigent programs, other third parties, self-pay, charity, and other payers.

(14) Total net patient revenues by payer including Medicare, Medi-Cal, county indigent programs, other third parties, and other payers.

(15) Other operating revenue.

(16) Nonoperating revenue net of nonoperating expenses.

~~(b) Hospitals reporting pursuant to subdivision (d) of Section 128760 may provide the items in paragraphs (7), (8), (9), (10), (14), (15), and (16) of subdivision (a) on a group basis, as described in subdivision (d) of Section 128760.~~

~~(c)~~

(b) The office shall make available at cost, to any person, a hard copy of any hospital report made pursuant to this section and in addition to hard copies, shall make available at cost, a computer tape of all reports made pursuant to this section within 105 days of the end of every calendar quarter.

~~(d)~~

(c) The office shall adopt by regulation guidelines for the identification, assessment, and reporting of charity care services. In establishing the guidelines, the office shall consider the principles and practices recommended by professional ~~health care~~ *healthcare* industry accounting associations for differentiating between charity services and bad debts. The office shall further conduct the onsite validations of health facility accounting and reporting procedures and records as are necessary to assure that reported data are consistent with regulatory guidelines.

~~This section shall become operative January 1, 1992.~~

SEC. 6. Section 128760 of the Health and Safety Code is amended to read:

128760. (a) On and after January 1, 1986, ~~those~~ *the* systems of health facility accounting and auditing formerly approved by the California Health Facilities Commission shall remain in full force and effect for use by health ~~facilities~~ *facilities,* but shall be maintained by the office.

(b) The office shall allow and provide, in accordance with appropriate regulations, for modifications in the accounting and reporting systems for use by health facilities in meeting the requirements of this chapter if the modifications are necessary to do any of the following:

(1) To correctly reflect differences in size of, provision of, or payment for, services rendered by health facilities.

(2) To correctly reflect differences in scope, type, or method of provision of, or payment for, services rendered by health facilities.

(3) To avoid unduly burdensome costs for those health facilities in meeting the requirements of differences pursuant to paragraphs (1) and (2).

(c) ~~Modifications to discharge data reporting requirements.~~ The office shall allow and provide, in accordance with appropriate regulations, for modifications to discharge data reporting format and frequency requirements if these modifications will not impair the office's ability to process the data or interfere with the purposes of this chapter. This modification authority shall not ~~be construed to~~ permit the office to administratively require the reporting of discharge data items not specified pursuant to Section 128735.

(d) ~~Modifications to emergency care data reporting requirements.~~ The office shall allow and provide, in accordance with appropriate regulations, for modifications to emergency care data reporting format and frequency requirements if these modifications will not impair the office's ability to process the data or interfere with the purposes of this chapter. This modification authority shall not be construed to permit the office to require administratively the reporting of emergency care data items not specified in subdivision (a) of Section 128736.

(e) ~~Modifications to ambulatory surgery data reporting requirements.~~ The office shall allow and provide, in accordance with appropriate regulations, for modifications to ambulatory surgery data reporting format and frequency requirements if these modifications will not impair the office's ability to process the data or interfere with the purposes of this chapter. The modification authority shall not be construed to permit the office to require administratively the reporting of ambulatory surgery data items not specified in subdivision (a) of Section 128737.

~~(f) Reporting provisions for health facilities. The office shall establish specific reporting provisions for health facilities that receive a preponderance of their revenue from associated comprehensive group practice prepayment health care service plans. These health facilities shall be authorized to utilize established accounting systems, and to report costs and revenues in a manner that is consistent with the operating principles of these plans and with generally accepted accounting principles. When these health facilities are operated as units of a coordinated group~~

~~of health facilities under common management, they shall be authorized to report as a group rather than as individual institutions. As a group, they shall submit a consolidated income and expense statement.~~

~~(g) Hospitals authorized to report as a group under this subdivision may elect to file cost data reports required under the regulations of the Social Security Administration in its administration of Title XVIII of the federal Social Security Act in lieu of any comparable cost reports required under Section 128735. However, to the extent that cost data is required from other hospitals, the cost data shall be reported for each individual institution.~~

~~(h)~~

(f) The office shall adopt comparable modifications to the financial reporting requirements of this chapter for county hospital systems consistent with the purposes of this chapter.

SEC. 7. Section 10181.45 of the Insurance Code is amended to read:

10181.45. (a) For large group health insurance policies, ~~each~~ *a* health insurer shall file with the department the weighted average rate increase for all large group benefit designs during the 12-month period ending January 1 of the following calendar year. The average shall be weighted by the number of insureds in each large group benefit design in the insurer's large group market and adjusted to the most commonly sold large group benefit design by enrollment during the 12-month period. For the purposes of this section, the large group benefit design includes, but is not limited to, benefits such as basic ~~health care~~ *healthcare* services and prescription drugs. The large group benefit design shall not include cost sharing, including, but not limited to, deductibles, copays, and coinsurance.

(b) (1) A health insurer shall also submit any other information required pursuant to any regulation adopted by the department to comply with this article.

(2) The department shall conduct an annual public meeting regarding large group rates within four months of posting the aggregate information described in this section in order to permit a public discussion of the reasons for the changes in the rates, benefits, and cost sharing in the large group market. The meeting

shall be held in either the Los Angeles area or the San Francisco Bay area.

(c) A health insurer subject to subdivision (a) shall also disclose the following for the aggregate rate information for the large group market submitted under this section:

(1) For rates effective during the 12-month period ending January 1 of the following year, number and percentage of rate changes reviewed by the following:

(A) Plan year.

(B) Segment type, including whether the rate is community rated, in whole or in part.

(C) Product type.

(D) Number of insureds.

(E) The number of products sold that have materially different benefits, cost sharing, or other elements of benefit design.

(2) For rates effective during the 12-month period ending January 1 of the following year, any factors affecting the base rate, and the actuarial basis for those factors, including all of the following:

(A) Geographic region.

(B) Age, including age rating factors.

(C) Occupation.

(D) Industry.

(E) Health status factors, including, but not limited to, experience and utilization.

(F) Employee, and employee and dependents, including a description of the family composition used.

(G) Insureds' share of premiums.

(H) Insureds' cost sharing, including cost sharing for prescription drugs.

(I) Covered benefits in addition to basic ~~health care~~ *healthcare* services, as defined in Section 1345 of the Health and Safety Code, and other benefits mandated under this article.

(J) Which market segment, if any, is fully experience rated and which market segment, if any, is in part experience rated and in part community rated.

(K) Any other factor that affects the rate that is not otherwise specified.

(3) (A) The insurer's overall annual medical trend factor assumptions for all benefits and by aggregate benefit category,

including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology for the applicable 12-month period ending January 1 of the following year. ~~A health insurer that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the health insurer's insureds shall instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories, to the maximum extent possible, that are the same or similar to those used by other insurers.~~

(B) The amount of the projected trend separately attributable to the use of services, price inflation, and fees and risk for annual policy trends by aggregate benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology. ~~A health insurer that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the insureds shall 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 insurers.~~

(C) A comparison of the aggregate per insured per month costs and rate of changes over the last five years for each of the following:

(i) Premiums.

(ii) Claims costs, if any.

(iii) Administrative expenses.

(iv) Taxes and fees.

(D) Any changes in insured cost sharing over the prior year associated with the submitted rate information, including both of the following:

(i) Actual copays, coinsurance, deductibles, annual out of pocket maximums, and any other cost sharing by the benefit categories determined by the department.

(ii) Any aggregate changes in insured cost sharing over the prior years as measured by the weighted average actuarial value, weighted by the number of insureds.

(E) Any changes in insured benefits over the prior year, including a description of benefits added or eliminated as well as

any aggregate changes as measured as a percentage of the aggregate claims costs, listed by the categories determined by the department.

(F) Any cost containment and quality improvement efforts made since the insurer's prior year's information pursuant to this section for the same category of health insurer. To the extent possible, the insurer shall describe any significant new ~~health care~~ *healthcare* cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period.

(G) The number of products covered by the information that incurred the excise tax paid by the health insurer.

(4) (A) For covered prescription generic drugs excluding specialty generic drugs, prescription brand name drugs excluding specialty drugs, and prescription brand name and generic specialty drugs dispensed at a pharmacy, network pharmacy, or mail order pharmacy for outpatient use, all of the following shall be disclosed:

(i) The percentage of the premium attributable to prescription drug costs for the prior year for each category of prescription drugs as defined in this subparagraph.

(ii) The year-over-year increase, as a percentage, in per-member, per-month total health insurer spending for each category of prescription drugs as defined in this subparagraph.

(iii) The year-over-year increase in per-member, per-month costs for drug prices compared to other components of the ~~health care~~ *healthcare* premium.

(iv) The specialty tier formulary list.

(B) The insurer shall include the percentage of the premium attributable to prescription drugs administered in a doctor's office that are covered under the medical benefit as separate from the pharmacy benefit, if available.

(C) (i) The insurer shall include information on its use of a pharmacy benefit manager, if any, including which components of the prescription drug coverage described in subparagraphs (A) and (B) are managed by the pharmacy benefit manager.

(ii) The insurer shall also include the name or names of the pharmacy benefit manager, or managers if the insurer uses more than one.

(d) The information required pursuant to this section shall be submitted to the department on or before October 1, 2016, and on

or before October 1 annually thereafter. Information submitted pursuant to this section is subject to Section 10181.7.

(e) For the purposes of this section, a "specialty drug" is one that exceeds the threshold for a specialty drug under the Medicare Part D program (Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173)).

SEC. 8. No reimbursement is required by this act pursuant to Section 6 of Article XIIIB 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.

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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.

Prepared by: Vincent D. Marchand / HEALTH / (916) 651-4111
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**** END ****

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California State Senate

SENATOR
DR. RICHARD PAN
SIXTH SENATE DISTRICT

CHAIR
HEALTH
BUDGET SUBCOMMITTEE
#3 ON HEALTH
& HUMAN SERVICES

COMMITTEES
BUDGET & FISCAL REVIEW
EDUCATION
BUSINESS, PROFESSIONS
& ECONOMIC DEVELOPMENT
HUMAN SERVICES
LABOR, PUBLIC EMPLOYMENT
& RETIREMENT

SB 343: Standardizing Disclosures for Health Plans and Hospitals

Purpose

SB 343, sponsored by SEIU California, will create uniformity in the data health plans and healthcare facilities are required to report to state regulators by removing provisions of law that allow Kaiser Permanente to report more limited information compared to all other health plans and hospitals.

Background on health plan provisions

Under existing law, health plans and health insurers are required to submit detailed data and actuarial justification for rate increases in the individual and small group markets, and to disclose aggregate rate increases in the large group markets, via reports to the Department of Managed Health Care or the Department of Insurance, which are available to the public. Though regulators do not have the authority to modify or reject rate changes, "rate review" has increased transparency on the factors contributing to the rising cost of health insurance.

As part of this rate review process, health plans are required to report the projected trend factor by benefit category, such as the projected cost increase for hospital inpatient, hospital outpatient, physician services, prescription drugs, and other ancillary services. However, Kaiser is specifically exempted from having to report projected assumptions, and instead is permitted to disclose its actual experience for the prior benefit year "using categories that are, to the maximum extent possible, the same or similar to those used by other plans." In practice, this has allowed Kaiser to propose rate increases without showing the underlying assumptions. Rate filings from other health plans, such as Blue Shield of California, show projected medical trend factor assumptions for various categories, such as hospital inpatient or outpatient, radiology, and laboratory services. Kaiser, on the other hand, lumps all of these into one "hospital inpatient" category, and just provides the actual trend factor from the prior 12 months rather than a projection for the year ahead. Kaiser has a very large market share in the large group market. Not having to report its assumptions for price increases across benefit categories, like every other health plan is required to do, prevents purchasers and regulators from being able to negotiate for more favorable terms or accurately judge whether the proposed rate increases are reasonable.

Background on hospital provisions

Under existing law, licensed health facilities are required to make certain reports to the Office of Statewide Health Planning and Development (OSHPD), including financial and utilization data, such as revenues by payer and by revenue center for individual hospitals. However, Kaiser hospitals are authorized to report costs and revenues as a group, so that all of their hospital's revenues are reported as a group for either Kaiser Permanent Southern California or Kaiser Permanente

Northern California. In practice, this has meant that the public has only a fraction of the information that other hospitals in the state provide. Allowing Kaiser to avoid reporting on a per facility basis has prevented purchasers and policy makers from comparing regional price variation and profitability (i.e., Bay Area vs. Sacramento) among Kaiser hospitals, unlike the data provided by each of Sutter Health's hospitals, for example.

This bill:

Creates more uniform reporting standards for health plans and hospitals by:

- Deleting Kaiser-specific language allowing a different method of reporting in individual, small group, and large group health plan and health insurance rate filings.
- Deleting Kaiser-specific language allowing more limited and aggregated hospital financial reporting to OSHPD.

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March 6, 2019

Senator Richard Pan
Chair, Senate Health Committee
State Capitol, Room 2191
Sacramento, CA 95814

RE: **SB 343 (Pan) – SUPPORT**

Dear Senator Pan:

The California Labor Federation supports your bill, SB 343, which will create uniformity in health plan and hospital reporting to state regulators by removing exemptions in existing law that allow Kaiser Permanente to report more limited information than other plans or facilities.

Rising health care costs have created an affordability crisis. Californians struggle to afford their premiums, deductibles, and co-pays and often ration their own care. Kaiser is one of the largest players in the health care industry in California, as a health plan, hospital, and medical group. Understanding Kaiser's financial status, cost drivers, and other information is critical to understanding and controlling health care costs.

Under existing law, health plans and health insurers are required to submit rate filings to the Department of Managed Health Care and Department of Insurance detailing cost drivers of premiums and other data. Regulators then review the filings for the individual and small group market and make determinations if rate increases are reasonable and justified or not.

However, Kaiser is specifically exempted from having to report certain information that other health plans are required to report in their rate filings. In practice, this has allowed Kaiser to propose rate increases without showing the underlying assumptions driving or justifying those increases. This exemption allows Kaiser to continue to increase rates in a black box hidden from regulators and the public. For purchasers in the large group market – employers and trust funds – this lack of information limits our ability to understand rising health care costs and negotiate for better rates.

Existing law requires licensed health facilities to make certain reports to the Office of Statewide Health Planning and Development (OSHPD). Kaiser hospitals again have an exemption in the law that allows them to report a fraction of the information that other hospitals provide. This exemption prevents purchasers, regulators, and researchers from investigating regional and facility differences and obscures the full financial picture of Kaiser.

SB 343 simply levels the playing field between Kaiser and all other health plans, insurers, and hospitals in the state by removing the "Kaiser exemption" in existing state reporting law.

For these reasons, we urge you to vote "YES" on SB 343 (Pan) when it comes before you in the Senate Health Committee.

Sincerely,

Sara Flocks
Public Policy Coordinator
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Cc: Committee Members

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February 26, 2019

Honorable Dr. Richard Pan, Chair
Senate Health Committee
State Capitol, Room 2191
Sacramento, CA 95814

RE: SB 343 (Pan) Healthcare Data Disclosure – SPONSOR & SUPPORT

Dear Senator Pan,

On behalf of our 700,000 members, the California State Council of the Service Employees International Union (SEIU California) is proud to sponsor SB 343 (Pan), your bill to remove Kaiser-specific exceptions to health insurance and hospital transparency specified in existing law. SB 343 (Pan) 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. Given that Kaiser health plan represents 40% of the insurance market, and one out of every ten California hospitals is a Kaiser facility, these data from Kaiser are crucial to policymakers' understanding of how California's healthcare markets are functioning. More importantly, 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.

While employers shoulder a significant share of healthcare costs, the impact on individual workers is even more severe. As the price of healthcare escalates, workers are left to shoulder the financial burden of higher premiums, co-pays and deductibles – an invisible form of compensation that does not go back into the family budget and the economy as a whole. A recent national study by the Economic Policy Institute shows that for family coverage, total employer sponsored insurance premiums rose from $5,791 in 1999 to $18,142 in 2016. For the bottom 90% of workers, this change meant the share of a worker's earnings going toward healthcare *doubled*, over the period. In real money, this is comparable to the loss of $12,350 per year for a family, or a foregone pay raise of 26%. In California, premiums for job-based health insurance have risen 249% since 2002 - more than six times the rate of general inflation.

What is worse - workers are paying more for their coverage, even when they use the same or fewer healthcare services. The transparency we now have 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%, which amounts to an additional $1.4 billion in premium costs. Despite limited detail on the justification for the proposed rate hike, the 2018 large group insurer rate filings demonstrated that *all* of Kaiser's 5.2% premium increases were due to price inflation, not utilization.

Transparency has been an effective tool for: 1) better understanding the underlying healthcare cost drivers, and 2) holding the industry accountable. California has enacted a series of successful laws to bring greater transparency to health insurance. In particular, SB 546 (Leno) Chapter 801, Statutes of 2015 requires insurers in the large group market (those with over 100 covered lives) to submit aggregate rate reports to California's two health insurance regulators, the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI), respectively. SB 546 also requires those regulators to hold an annual public meeting on large employer market rate filings.

Existing laws for large group market rate review effectively exempt Kaiser from requirements placed on all other insurers to provide their projected trend factor by benefit category. Rather, Kaiser alone is allowed to rely on actual experience from the prior benefit year, using categories that are, "the maximum extent possible, the same or similar to those used by other plans" in rate filings. In practice, this has allowed Kaiser to sidestep the requirement altogether and propose rate increases without demonstrating their underlying assumptions to regulators or purchasers. Rate filings from other health plans, such as Blue Shield of California, show projected medical trend factor assumptions for various categories, such as hospital inpatient or outpatient, radiology, and laboratory services. Kaiser's report collapses all these benefit categories into a single aggregate "hospital inpatient" number and uses the actual trend factor from the prior 12 months as justification, rather than a projection for the year ahead. Given that Kaiser health plan dominates the large group insurance market with 58% market share, this lack of transparency has a huge impact on California workers and their employers.

In addition to removing Kaiser's insurance reporting exemption, SB 343 would strike Kaiser's unique exemption to facility-based hospital reporting under the Office of Statewide Health Planning and Development (OSHPD), which permits Kaiser to report costs and revenues regionally, rather than by hospital. Due to the regional variation in hospital prices across California, particularly between Northern and Southern California, it is important to understand Kaiser's hospitals as they contribute to overall hospital pricing, as well as Kaiser's insurance rates.

There was a time when Kaiser's integrated delivery model was truly novel. In the years since Kaiser's phenomenal economic success – Kaiser currently has $31 billion in reserves and $2.5 billion in net profits – many other health systems have adopted the integrated delivery system model. 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. It is for those reasons that we are proud to support your SB 343.

Sincerely,

Michelle Doty Cabrera
Healthcare Director

EXECUTIVE BOARD
DAVE HAWLEY
CO-CHAIRMAN - PRESIDENT
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981 CORPORATE CENTER DR. STE. 200
POMONA, CA 91768

CALIFORNIA TEAMSTERS PUBLIC AFFAIRS COUNCIL
1127 ELEVENTH STREET, SUITE 512
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(916) 446-0291
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E-MAIL: INFO@TEAMSTERCTPAC.ORG
WWW.CATEAMSTERS.COM

To: All Members of the Senate Health Committee

From: Shane Gusman
Matt Broad

Re: SB 343 (Pan) - **SUPPORT**

Date: March 4, 2019

The California Teamsters support SB 343 by Senator Richard Pan.

SB 343 would 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. Given that Kaiser health plan represents 40% of the insurance market, and one out of every ten California hospitals is a Kaiser facility, these data from Kaiser are crucial to policymakers' understanding of how California's healthcare markets are functioning. More importantly, 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.

The Teamsters have historically supported measures that promote transparency across the healthcare industry. The cost of healthcare has grown more unaffordable by the year, making it increasingly difficult to bargain with our employers on raises for Teamster members. Transparency continues to be an effective tool for: 1) better understanding the underlying healthcare cost drivers, and 2) holding the industry accountable. California has enacted a series of successful laws to bring greater transparency to health insurance. SB 546 (Leno) Chapter 801, Statutes of 2015 requires insurers in the large-group market (those with over 100 covered lives) to submit aggregate rate reports to California's two health insurance regulators, the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI), respectively. SB 546 also requires those regulators to hold an annual public meeting on large employer market rate filings.

In addition to removing Kaiser's insurance reporting exemption, SB 343 would strike Kaiser's unique exemption to facility-based hospital reporting under the Office of Statewide Health Planning and Development (OSHPD), which permits Kaiser to report costs and revenues regionally, rather than by hospital. Due to the regional variation in hospital prices across California, particularly between Northern and Southern California,

it is important to understand Kaiser's hospitals as they contribute to overall hospital pricing, as well as Kaiser's insurance rates.

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. It is for those reasons that we are proud to support SB 343.

On behalf of the California Teamsters, we urge your "AYE" vote on SB 343.

cc: Senator Richard Pan

HEALTH ACCESS CALIFORNIA

February 26, 2019

The Honorable Dr. Richard Pan, Chair
Senate Health Committee
State Capitol
Sacramento, CA 95814

Re: SB 343 (Pan) – Support

Dear Senator Pan,

Health Access California, the statewide health care consumer advocacy coalition committed to quality, affordable health care for all Californians is pleased to support SB 343 (Pan) which as introduced would create uniformity in the data health plans and health care facilities are required to report to state regulators by removing provisions of law that allow Kaiser Permanente to report more limited information compared to all other health plans and hospitals.

Health Access California has long supported and sponsored legislation to improve transparency and reporting requirements in the health care industry. In order to tackle the issue of rising health care costs, there must be transparent, comprehensive, and comparable data throughout the system in order to come up with evidence-based solutions. Kaiser Permanente dominates the large group market (over 10 million lives in total) with a 58% share. For years, 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, which leaves regulators and policymakers in the dark. A second year of financial disclosures (made pursuant by SB 546, Leno) show that health care provider costs continue to comprise the largest proportion of overall health care spending, and that prices, not utilization, contribute more to the rising premiums[1]. This underscores the need for more uniform data across sectors, in order to make better comparisons of health care costs.

SB 343 will create more uniform reporting standards for health plans and hospitals by removing Kaiser-specific language allowing a different method of reporting of health plan and health insurance rate filings to DMHC, and removing Kaiser-specific language allowing more limited and aggregated hospital financial reporting to OSHPD.
For these reasons we are pleased to support this measure.

Sincerely,

Anthony Wright
Executive Director

1127 11th Street, Suite 925, Sacramento, CA 95814 • 916-497-0923 • info@health-access.org • health-access.org

CC: Members and Staff of the Senate Health Committee
Senator Richard Pan, Author

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[1] UNITE HERE, It's Still the Prices: Second Year Data from California's Rate Filing Law, September 2018

BROAD & GUSMAN
GOVERNMENTAL ADVOCACY

To: All Members of the Senate Committee on Health

From: Shane Gusman
Matt Broad

Date: March 4, 2019

Re: SB 343 (Pan) - **SUPPORT**

Clients: UNITE-HERE, AFL-CIO
CA Conference of Machinists
Utility Workers of America
Inlandboatmen's Union of the Pacific
Engineers and Scientists of CA, IFPTE Local 20, AFL-CIO
Professional and Technical Engineers, IFPTE Local 21, AFL-CIO
CA Conference Board of the Amalgamated Transit Union
SAG-AFTRA

The above unions support SB 343 by Senator Richard Pan.

SB 343 would 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. Given that Kaiser health plan represents 40% of the insurance market, and one out of every ten California hospitals is a Kaiser facility, these data from Kaiser are crucial to policymakers' understanding of how California's healthcare markets are functioning. More importantly, 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.

We have historically supported measures that promote transparency across the healthcare industry. The cost of healthcare has grown more unaffordable by the year, making it increasingly difficult to bargain with our employers on raises for our members. Transparency continues to be an effective tool for: 1) better understanding the underlying healthcare cost drivers, and 2) holding the industry accountable. California has enacted a series of successful laws to bring greater transparency to health insurance. In particular, SB 546 (Leno) Chapter 801, Statutes of 2015 requires insurers in the large group market (those with over 100 covered lives) to submit aggregate rate reports to California's two health insurance regulators, the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI), respectively. SB 546 also requires those regulators to hold an annual public meeting on large employer market rate filings.

In addition to removing Kaiser's insurance reporting exemption, SB 343 would strike Kaiser's unique exemption to facility-based hospital reporting under the Office of Statewide Health Planning and Development (OSHPD), which permits Kaiser to report costs and revenues regionally, rather than by hospital. Due to the regional variation in hospital prices across California, particularly between Northern and Southern California, it is important to understand

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Sacramento, CA 95814
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Kaiser's hospitals as they contribute to overall hospital pricing, as well as Kaiser's insurance rates.

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. It is for those reasons that we are proud to support SB 343.

On behalf of the above unions, we urge your "AYE" vote on SB 343.

cc: Senator Richard Pan

SMALL BUSINESS MAJORITY

March 20, 2019

The Honorable Dr. Richard Pan, Chair
Senate Health Committee
State Capitol, Room 2191
Sacramento, CA 95814

RE: Legislation pending on Healthcare Data Disclosure (SB 343)

Dear Senator Pan,

As a representative of the 30 million small businesses in America and the more than 3.9 million in California, Small Business Majority writes today in support of SB 343, which would create healthcare data transparency parity across California's healthcare industry. Requiring uniform disclosure information about healthcare usage, costs and outcomes would further efforts to improve affordability and quality of existing healthcare options.

Small Business Majority is a national small business advocacy organization with multiple offices throughout California, founded and run by small business owners to ensure America's entrepreneurs are a key part of a thriving and inclusive economy. We actively engage small business owners and policymakers in support of public policy solutions, and deliver information and resources to entrepreneurs that promote small business growth and drive a strong, sustainable job-creating economy. A key component of our work involves outreach and education to small business owners on a range of small business issues, including healthcare, retirement security, access to capital and more.

While millions of Californians have gained healthcare coverage in recent years, many still struggle to afford medical costs for copays and deductibles, making it difficult to actually use the coverage they have. And while the rate of annual increases in premiums and healthcare costs has slowed post-Affordable Care Act, there is a continued lack of transparency in healthcare costs that makes it difficult for consumers to understand how much they will spend on medical care or compare costs across providers. This problem is complicated by existing exemptions in reporting requirements for Kaiser Permanente, the state's largest healthcare provider. Without access to all healthcare providers' rates and financial information, California consumers and lawmakers cannot fully understand the drivers of healthcare costs in California.

Small business owners are concerned about rising healthcare costs, and support commonsense solutions to lower costs. Our scientific opinion polling shows that 91% of California's small business owners agree there should be more transparency on pricing and quality to allow patients to make informed decisions about where they receive care.

SB 343 would address the issues around lack of transparency by creating more uniform reporting standards for health plans and hospitals. This could significantly improve affordability for all Californians, including many entrepreneurs and small business employees. Requiring greater transparency from Kaiser would bring them in line with the rest of the healthcare industry, which will in turn help lower healthcare costs for California's business owners by ensuring employers have access to adequate information about rates and cost drivers behind California's healthcare.

We urge you to support SB 343 to further promote transparency and affordability in California's healthcare marketplaces.

Sincerely,

Mark Herbert, California Director
Small Business Majority

921 11th St., Suite 902 • Sacramento, CA 95814 • (866) 597-7431 • www.smallbusinessmajority.org

Silicon Valley Employers Forum
400 Concar Drive
San Mateo, CA 94402

May 30, 2019

Senator Pan
California State Capitol
Sacramento, CA 95814

RE: Senate Bill 343 (Pan) Healthcare data disclosure - SUPPORT

Dear Senator Pan:

On behalf of the Silicon Valley Employers Forum, a 501(C6) association representing over 50 high tech employers who sponsor healthcare benefits for its employees and families, I am writing in support of SB 343 (Pan) which will create reporting parity in California's healthcare industry. California law currently requires aggregate rate reporting broken out by benefit category and requires each hospital to report facility-level data. This bill would repeal Kaiser's exceptions bringing them in line with the rest of the healthcare industry, ensuring that consumers, policymakers, and employers have adequate information understand the rates and costs drivers behind healthcare in California.

As the cost of healthcare increase, California's are left to pick up a larger share of the costs. According to the Kaiser Family Foundation Employer Health Benefits Survey, "since 2008 premiums have increased 55%, twice as fast as workers earnings and three times as fast as inflations."[1] Rising healthcare costs eat into workers paychecks. However, in California, it is difficult to find the true costs of healthcare because Kaiser, the largest healthcare provider in California has exceptions to reporting data unlike the rest of the healthcare industry. Given that Kaiser's health plan is 40% of the California's insurance market, not having Kaiser's rate and financial data means that we do not have a clear picture of healthcare costs in California.

SB 343 (Pan) will simply remove Kaiser's exception, bringing them in line with the rest of the industry. Having uniformed data disclosure will allow consumers and policymakers to make an "apples to apples" comparison of the true costs of healthcare. This bill will ensure that purchasers of healthcare, like large employers or union trust funds, have adequate information when choosing to purchase healthcare plans. Additionally, without adequate healthcare cost data, policymakers are limited in their actions to lower the cost of care for all California's.

SB 343 (Pan), is a measured step to ensure consumers, policymakers, and employers have adequate information to understand the rates and costs drivers behind healthcare in California. For all these reasons, we respectfully request an "aye" vote when SB 343 (Pan) comes before you in committee.

Sincerely,

Lisa Yee
Executive Director
(650) 880-2585

CC: Vince Marchand, Vince.Marchand@sen.ca.gov

Matt Lege, Government Relations Advocate SEIU-UHW, mlege@seiu-uhw.org

[1] https://www.kff.org/health-costs/press-release/employer-sponsored-family-coverage-premiums-rise-5-percent-in-2018/

Print Form

Introduction Form

By a Member of the Board of Supervisors or Mayor

RECEIVED
BOARD OF SUPERVISORS
SAN FRANCISCO
2019 JUN 11 PM 1:03
BY: dr

Time stamp or meeting date

I hereby submit the following item for introduction (select only one):

- ☐ 1. For reference to Committee. (An Ordinance, Resolution, Motion or Charter Amendment).
- ☑ 2. Request for next printed agenda Without Reference to Committee.
- ☐ 3. Request for hearing on a subject matter at Committee.
- ☐ 4. Request for letter beginning :"Supervisor _____ inquiries"
- ☐ 5. City Attorney Request.
- ☐ 6. Call File No. _____ from Committee.
- ☐ 7. Budget Analyst request (attached written motion).
- ☐ 8. Substitute Legislation File No. _____
- ☐ 9. Reactivate File No. _____
- ☐ 10. Topic submitted for Mayoral Appearance before the BOS on _____

Please check the appropriate boxes. The proposed legislation should be forwarded to the following:

☐ Small Business Commission ☐ Youth Commission ☐ Ethics Commission

☐ Planning Commission ☐ Building Inspection Commission

Note: For the Imperative Agenda (a resolution not on the printed agenda), use the Imperative Form.

Sponsor(s):

Mar; Peskin, Brown, Haney

Subject:

Support for State Senate Bill 343 Uniform Healthcare Data Disclosure

The text is listed:

Resolution supporting California State Senate Bill 343 by State Senate Health Committee Chair Richard Pan to create uniform healthcare data disclosures and parity in data reporting across the healthcare industry, in the expectation that uniform data will more fully inform health insurance purchasing decisions by the City and County of San Francisco and all other purchasers in the City and County.

Signature of Sponsoring Supervisor:

For Clerk's Use Only