LEGISLATION COMMITTEE

May 14, 2018
10:30 A.M.
651 Pine Street, Room 101, Martinez

Agenda

Supervisor Karen Mitchoff, Chair
Supervisor Diane Burgis, Vice Chair

Agenda Items:	Items may be taken out of order based on the business of the day and preference of the Committee

1. Introductions

2. Public comment on any item under the jurisdiction of the Committee and not on this agenda (speakers may be limited to three minutes).

3. **APPROVE the Record of Action for the April 9, 2018 meeting of the Legislation Committee with any necessary corrections.**

4. **ACCEPT the reports to be presented to the Committee at the meeting regarding the Governor's Revised Budget for FY 2018-19 and provide direction to staff.**

5. **CONSIDER recommending to the Board of Supervisors a position of "Oppose" on AB 2293 (Reyes): Emergency Medical Services: Licensure, a bill that would limit and narrow the types of crimes and violations that can result in the denial of an application for emergency medical technician-paramedic (EMT-P) license, as recommended by Patricia Frost, Emergency Medical Services Director of Contra Costa County.**

6. **CONSIDER recommending to the Board of Supervisors a position of "Support, if funded" for AB 2043 (Arambula), a bill that requires the Department of Social Services to establish a statewide hotline as the entry point for a Family Urgent Response System to respond to calls from caregivers or current or former foster youth when a crisis arises; and "Support" for AB 2083 (Cooley), a bill that requires county-level Memorandums of Understanding (MOUs) between agencies directly responsible for the most-traumatized children in foster care, as recommended by the Director of the Employment and Human Services Department.**

7. **CONSIDER recommending to the Board of Supervisors a position of "Oppose unless amended" on AB 3087 (Kalra), a bill that creates the State Health Care Cost, Quality, and Equity Commission, an independent state agency, to control in-state health care costs and set the amounts accepted as payment by health plans, hospitals, physicians, and other health care provider and requires the**

Commission to annually determine the base amounts that health care entities are required to accept as full payment for health care service, as recommended by the Chief Executive Officer of the Contra Costa Health Plan.

8. **CONSIDER recommending to the Board of Supervisors a position of "Support" for SB 910 (Hernandez): Short-term Limited Duration Health Insurance, a bill that prohibits a health insurer from issuing, selling, renewing, or offering a short-term limited duration health insurance policy for health care coverage in this state, as recommended by the Chief Executive Officer of the Contra Costa Health Plan.**

9. **CONSIDER recommending to the Board of Supervisors a position of "Support" on SB 974 (Lara): Medi-Cal: Immigration Status: Adults, a bill that extends full-scope Medi-Cal benefits to undocumented adults age 19 and above who are otherwise eligible for those benefits but for their immigration status, as recommended by the Chief Executive Officer of the Contra Costa Health Plan .**

10. **CONSIDER recommending to the Board of Supervisors a position of "Support" on SB 1105 (Skinner): Vehicles: Driving Offenses: Prosecution, a bill that would extend existing laws relating to the dismissal of Vehicle Code violations pending at the time of a defendant's commitment to state prison or county jail on a jail-eligible felony to provide the same relief to persons sentenced to county jail or other alternatives to incarceration, as recommended by the Deputy Director of the Office of Reentry and Justice.**

11. **CONSIDER providing feedback on SB 828 (Weiner) and AB 1771 (Bloom): Planning and Zoning: Regional Housing Needs Assessment, as requested by California State Association of Counties (CSAC) staff.**

12. **CONSIDER recommending a position of “Support” to the Board of Supervisors for H.R. 5003 to amend the Internal Revenue Code of 1986 to reinstate advance refunding bonds and authorize the Chair of the Board to send a letter to the County's congressional delegation requesting co-sponsorship of the bill, as recommended by the Chief Assistant County Administrator.**

13. The next meeting is currently scheduled for Monday, June 11, 2018 at 10:30 a.m.

14. Adjourn

The Legislation Committee will provide reasonable accommodations for persons with disabilities planning to attend Legislation Committee meetings. Contact the staff person listed below at least 72 hours before the meeting.

Any disclosable public records related to an open session item on a regular meeting agenda and distributed by the County to a majority of members of the Legislation Committee less than 96 hours prior to that meeting are available for public inspection at 651 Pine Street, 10th floor, during normal business hours.

Public comment may be submitted via electronic mail on agenda items at least one full work day prior to the published meeting time.

For Additional Information Contact:

Lara DeLaney, Committee Staff
Phone (925) 335-1097, Fax (925) 646-1353
lara.delaney@cao.cccounty.us

Contra Costa County Board of Supervisors

Subcommittee Report

LEGISLATION COMMITTEE **3.**

Meeting Date:	05/14/2018
Subject:	Record of Action for Legislation Committee
Submitted For:	LEGISLATION COMMITTEE,
Department:	County Administrator
Referral No.:	2018-10
Referral Name:	Record of Action
Presenter:	L. DeLaney **Contact:** L. DeLaney, 925-335-1097

Referral History:

County Ordinance (Better Government Ordinance 95-6, Article 25-205, [d]) requires that each County Body keep a record of its meetings. Though the record need not be verbatim, it must accurately reflect the agenda and the decisions made in the meeting.

Any handouts or printed copies of material or testimony distributed at the meeting will be attached to the meeting record.

Referral Update:

Attached for the Committee's consideration is the Draft Record of Action for its April 9, 2018 meeting.

Recommendation(s)/Next Step(s):

APPROVE the Record of Action with any necessary corrections.

Fiscal Impact (if any):

None.

Attachments

Draft Record of Action

D R A F T

LEGISLATION COMMITTEE

April 9, 2018
10:30 A.M.
651 Pine Street, Room 101, Martinez

Agenda

Supervisor Karen Mitchoff, Chair
Supervisor Diane Burgis, Vice Chair

Agenda Items:	Items may be taken out of order based on the business of the day and preference of the Committee

Present: Karen Mitchoff, Chair
Diane Burgis, Vice Chair

Staff Present: Lia Bristol, Deputy Chief of Staff, District IV
Mark Goodwin, Chief of Staff, District III
Donte Blue, Deputy Director, Office of Reentry & Justice
Allison Pruitt, Policy & Planning Division, EHSD
Emlyn Struther, Clerk of the Board staff
Lara DeLaney, Senior Deputy County Administrator

1. Introductions

The Committee members and attendees introduced themselves. Ben Palmer from Nielsen Merksamer was on a conference call line.

2. Public comment on any item under the jurisdiction of the Committee and not on this agenda (speakers may be limited to three minutes).

No public comment was made.

3. APPROVE the Record of Action with any necessary corrections.

The Committee voted unanimously to accept the Record as presented.

AYE: Chair Karen Mitchoff, Vice Chair Diane Burgis
Passed

4.

The Committee directed staff to watch AB 2043 (Arambula), a bill that requires county child welfare, probation, and behavioral health agencies to establish county-based Family Urgent Response System, and provide additional information on the fiscal impact to counties. No vote was taken.

5. CONSIDER recommending to the Board of Supervisors a position of "Support" on AB 2083 (Cooley): Foster Youth: Trauma-Informed System of Care, as recommended by the Director of Employment and Human Services, and direct staff to place the item on the Board's consent calendar for April 24, 2018.

   The Committee declined to take action on the bill, requesting additional information from staff and citing concerns about any kind of state mandate, as our County has already implemented trauma-informed care through the Alliance to End Abuse.

6. CONSIDER recommending to the Board of Supervisors a position of "Support" on State Water Supply Infrastructure, Water Conveyance, Ecosystem and Watershed Protection and Restoration, and Drinking Water Protection Act of 2018.

   The Committee voted unanimously to recommend support of the measure to the Board of Supervisors and directed staff to send to the Board on consent.

   AYE: Chair Karen Mitchoff, Vice Chair Diane Burgis
   Passed

7. CONSIDER recommending to the Board of Supervisors a position of "Support" on SB 1392 and SB 1393 and directing staff to place the bills on the Board's Consent calendar for April 24, 2018.

   The Committee declined to vote on these bills, requesting further input from the County's justice system partners.

8. The next meeting is currently scheduled for May 14, 2018 at 10:30 a.m.

9. Adjourn

The Legislation Committee will provide reasonable accommodations for persons with disabilities planning to attend Legislation Committee meetings. Contact the staff person listed below at least 72 hours before the meeting.

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Public comment may be submitted via electronic mail on agenda items at least one full work day prior to the published meeting time.

For Additional Information Contact:

Lara DeLaney, Committee Staff
Phone (925) 335-1097, Fax (925) 646-1353
lara.delaney@cao.cccounty.us

Contra Costa County Board of Supervisors

Subcommittee Report

LEGISLATION COMMITTEE **4.**

Meeting Date: 05/14/2018
Subject: Governor's Revised Budget Plan for FY 2018-19
Submitted For: LEGISLATION COMMITTEE,
Department: County Administrator
Referral No.: 2018-12
Referral Name: State Budget
Presenter: Cathy Christian & Ben Palmer **Contact:** L. DeLaney, 925-335-1097

Referral History:

As a Governor does each year, Governor Brown is expected to release his revised budget for FY 2018-19 on Friday, May 11, 2018 at a news conference in Sacramento at 10:00 a.m. This news conference will be webcast at: http://www.calchannel.com.

Referral Update:

The California State Association of Counties, the Urban Counties of California, and others will be providing summaries of the budget proposal that are not available at time of publication. Our state advocates and staff will provide summary information at the meeting on May 14, 2018.

Recommendation(s)/Next Step(s):

ACCEPT the reports to be presented to the Committee at the meeting regarding the Governor's Revised Budget for FY 2018-19 and provide direction to staff.

Attachments

No file(s) attached.

Contra Costa County Board of Supervisors

Subcommittee Report

LEGISLATION COMMITTEE **5.**

Meeting Date:	05/14/2018
Subject:	AB 2293 (Reyes): Emergency Medical Services: Licensure
Submitted For:	LEGISLATION COMMITTEE,
Department:	County Administrator
Referral No.:	2018-14
Referral Name:	AB 2293 (Reyes): Emergency Medical Services: Licensure
Presenter:	Patricia Frost **Contact:** Patricia Frost, 925-313-9554

Referral History:

Patricia Frost, Director of Emergency Medical Services for Contra Costa County, is recommending a position of "Oppose" on AB 2293. **Attachment A** is a letter from EMSAAC and EMDAAC that provides the California EMS Agency Administrators' and Medical Directors' concerns associated with this bill.

Author:	Eloise Gomez Reyes (D-047)
Title:	Emergency Medical Services: Licensure
Fiscal Committee:	yes
Urgency Clause:	no
Introduced:	02/13/2018
Last Amend:	04/26/2018
Disposition:	Pending
Committee:	Assembly Appropriations Committee
Hearing:	05/09/2018 9:00 am, State Capitol, Room 4202
Summary:	Amends existing law relating to investigations and disciplinary actions against EMTs for specified conduct. Modifies the criteria related to conduct that the authority may consider in denying an EMT application. Permits the authority to consider whether an applicant demonstrates substantial rehabilitation. Extends the time for an applicant to file a notice of defense from 15 to 30 days in response to a denied EMT application.

Referral Update:

The text of AB 2293 is available here:
http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180AB2293

2017 CA A 2293: Bill Analysis - 05/07/2018 - Assembly Appropriations Committee, Hearing Date 05/09/2018

Date of Hearing: May 9, 2018

ASSEMBLY COMMITTEE ON APPROPRIATIONS

Lorena Gonzalez Fletcher, Chair

AB 2293

(Reyes) - As Amended April 26, 2018 Policy Health Vote: 12 - 3 Committee: Urgency: No State Mandated Reimbursable: No Local Program: No **SUMMARY**:

For purposes of an application for emergency medical technician-paramedic (EMT-P) license, this bill would limit and narrow the types of crimes and violations that can result in the denial of the application. Specifically, this bill:

1) Allows the Emergency Medical Services Authority (EMSA) to deny an EMT-paramedic application for specified reasons, which are narrower than those under existing law, unless the applicant can demonstrate substantial rehabilitation, as defined.

2) Narrows many of the potentially disqualifying acts to only those acts committed in the course of employment or those directly related to an EMT-P's qualifications, functions, and duties.

3) Allows EMSA to suspend its application review pending resolution of a criminal proceeding related to a sexual offense, as specified.

4) Prohibits EMSA from denying an application based on convictions that have been dismissed, pardoned, or expunged or for which a certificate of rehabilitation has been issued.

5) Prohibits EMSA from denying an application based on arrests, infractions, or citations, as specified, or a matter adjudicated in juvenile court.

FISCAL EFFECT:

Costs to EMSA in the range of $500,000 annually for at least three years to revise regulations and guidelines, process additional new applications, and information technology changes to the central EMS registry (GF, or Emergency Medical Services Personnel Fund with an estimated fee increase of $12 per license). Ongoing costs are expected to be minor once the required changes are made.

COMMENTS:

1) Purpose. According to the author, recent wildfires demonstrate the need for additional firefighters and EMTs. The author contends under current law EMSA denies qualified individuals based purely on a past criminal history. This bill reduces barriers for individuals who have already served their time to have an opportunity for employment that requires an EMT-P license.

2) Background. An EMT is a trained-and-certified or licensed professional who renders immediate medical care in the pre-hospital setting to seriously ill or injured individuals. California has three levels of EMTs: EMT-I (basic), EMT-II (also known as advanced EMT), and EMT-P (paramedic). Paramedics must meet higher training requirements compared to EMT-Is and IIs, and have a broader scope of practice. There are nearly 22,000 licensed EMT-Ps in California.

This Legislature, think-tanks, and advocacy groups have recently demonstrated interest in reducing barriers for formerly incarcerated persons. Occupational licensure for formerly incarcerated persons, which generally include background checks that can disqualify a person from licensure, pose a significant barrier to entry in many professions.

3) Current Process. According to the National Registry of EMTs, EMS professionals under the authority of state licensure have unsupervised, intimate, physical and emotional contact with patients at a time of maximum physical and emotional vulnerability, as well as unsupervised access to a patient's personal property. They note EMS professionals, therefore, are placed in a position of the highest public trust. Accordingly, the National Registry has adopted criminal conviction policies for issuing certifications to safeguard the public and preserve public trust. In order to work as an EMT or paramedic in California, an individual must first pass the National Registry certification test.

At the state level, model disciplinary orders were developed by EMSA in consultation with emergency medical services constituent groups from across the state to provide consistent and equitable treatment for violations and denial of applications.

4) Prior Legislation. AB 1931 (Rodriguez), of the current session, would have added EMT-Ps to the provisions of law governing the procedures for investigations and disciplinary actions that are current law for EMT-Is and IIs. AB 1931 was held on the Senate Appropriations Suspense File.

AB 1008 (McCarty), Chapter 789, Statutes of 2017, prohibits an employer, with certain exceptions, from inquiring about or considering a job applicant's conviction history prior to a conditional offer of employment, and sets requirements regarding the consideration of conviction histories in employment decisions

5) Staff Comment. In ongoing discussions about this bill since it passed the policy committee, concerns have been raised about conflict between this bill and conviction policy for the federal EMT certification that could render this bill's attempt to relax certification standards moot. In other words, unless federal policy changes or the state takes the dramatic step of no longer requiring federal certification, a person could be federally disqualified for many of the acts this bill would allow on a licensed EMT-P's record.

Analysis Prepared by: Lisa Murawski / APPR. / (916) 319-2081

Recommendation(s)/Next Step(s):

Fiscal Impact (if any):

CONSIDER recommending to the Board of Supervisors a position of "Oppose" on AB 2293 (Reyes), a bill that would limit and narrow the types of crimes and violations that can result in the denial of an application for emergency medical technician-paramedic (EMT-P) license and direct staff to submit to a Board agenda for consent.

Attachments

Attachment A: Oppose Letter

Emergency Medical Services Administrator's Association of California

EMDAC

May 9, 2018

Alameda
Central California
Coastal Valleys
Contra Costa
El Dorado
Imperial
Inland Counties
Kern
Los Angeles
Marin
Merced
Monterey
Mountain-Valley
Napa
North Coast
Northern California
Orange
Riverside
Sacramento
San Benito
San Diego
San Francisco
San Joaquin
San Luis Obispo
San Mateo
Santa Barbara
Santa Clara
Santa Cruz
Sierra-Sac Valley
Solano
Tuolumne
Ventura
Yolo

The Honorable Lorena Gonzalez Fletcher
Chair, Assembly Appropriations Committee
State Capitol, Room 2114
Sacramento, CA 95814

RE: AB 2293/Reyes – Emergency medical services: licensure
As Amended April 26, 2018 – OPPOSE
Set for Hearing May 4, 2018 – Assembly Appropriations Committee

Dear Assembly Member Gonzalez Fletcher:

The Emergency Medical Services Administrators Association of California (EMSAAC) and the Emergency Medical Directors Association of California (EMDAC) strongly oppose AB 2293 by Assembly Member Eloise Gómez Reyes, which amends Health and Safety Code Section 1798.200 by severely restricting the ability of the local EMS agency (LEMSA) medical directors and the director of the EMS Authority to protect the public's health and safety by denying licenses to applicants or imposing disciplinary action against EMTs, EMT-IIs, and paramedics.

Existing statutory standards for discipline of pre-hospital personnel were developed in collaboration with numerous EMS stakeholders to ensure both patient safety and the opportunity for individuals to not be unnecessarily excluded from certification for past criminal convictions unrelated to the duties, qualifications and functions of prehospital medical care personnel. We are extremely concerned that AB 2293 will eliminate safeguards placing patients at serious risk from individuals posing a serious threat to the public's health and safety. Pre-hospital personnel serve on ambulances, emergency response apparatus, and remote first-aid areas providing services to vulnerable patients, many who are elderly and alone, in their homes with little direct supervision. For this reason and others we believe that standards for who is eligible for certification and licensure should remain high.

Most troubling is that this bill strikes the authority of local EMS agencies and the EMS Authority to deny certification or licensure to any applicant regardless of the seriousness of past criminal history including violent sex offenders and convicted pedophiles. While this may not be the intent of the bill, it is the result.

Additionally, this bill will increase costs for local EMS agencies ranging in the tens of thousands of dollars due to required revisions to policies, an expected increase in the volume of applications from individuals with serious criminal histories requiring in depth evaluation, ensuring fire department and ambulance compliance with revised standards, and the potential for more complex and more frequent administrative law proceedings and the setting of new legal precedents. The EMS Authority will likely face a similar increase in costs related to this bill.

EMSAAC represents the 33 local emergency medical services (EMS) agency administrators representing all of California's 58 counties. The mission of the Emergency Medical Directors Association of California, Inc. (EMDAC) is to provide leadership and expert opinion in the medical oversight, direction and coordination of Emergency Medical Services for the people of the State of California.

If you should have any questions, please contact EMSAAC's Legislative Chair Dan Burch at (209) 468-6818.

Sincerely,

Michael Petrie
EMSAAC President

Kevin Mackey, MD
EMDAC President

cc: The Honorable Eloise Gómez Reyes, Member, California State Assembly
Honorable Members, Assembly Appropriations Committee
Lisa Murawski, Consultant, Assembly Appropriations Committee
Peter Anderson, Consultant, Assembly Republican Caucus

Contra Costa County Board of Supervisors

Subcommittee Report

LEGISLATION COMMITTEE **6.**

Meeting Date: 05/14/2018
Subject: AB 2043 (Arambula) and AB 2083 (Cooley)--RECONSIDERATION
Submitted For: LEGISLATION COMMITTEE,
Department: County Administrator
Referral No.: 2018-20
Referral Name: AB 2043 and AB 2083
Presenter: Maura Connell, EHSD **Contact:** L. DeLaney, 925-335-1097

Referral History:
AB 2043 (Arambula): Foster Youth: Family Urgent Response System and AB 2083 (Cooley): Foster Youth: Trauma-Informed System of Care were considered by the Legislation Committee at their April 9, 2018 meeting. The Committee requested further information from staff; no votes were taken on the bills at that time. EHSD staff is providing the Committee additional information for the Committee's reconsideration of the bills.

AB 2043 requires, by January 1, 2020, county child welfare, probation, and behavioral health agencies to establish county-based Family Urgent Response Systems for the provision of mobile crisis-response services to current or former foster youth and their caregivers, and, by that same date, requires the Department of Social Services (DSS) to establish a statewide hotline, to be available 24 hours per day, seven days per week to respond to caregiver or youth calls when a crisis arises.

Disposition: Pending
Location: Assembly Appropriations Committee

AB 2083 requires county-level Memorandums of Understanding (MOUs) between agencies directly responsible for the most-traumatized children in foster care and requires the Secretary of California Health and Human Services and the Superintendent of Public Instruction (SPI) to implement and review aspects of the MOUs.

Disposition: Pending
Location: Assembly Appropriations Committee

Referral Update:

Employment and Human Services Department (EHSD) staff offers the following additional information for the Supervisors reconsideration of the bills. Unfortunately, they were not able to confirm the funding details that were of special concern to the Supervisors, as the legislative process for these bills is still in motion.

Staff recommends supporting the Bay Area regional counties for AB 2043 (Urgent Response System), "contingent upon the requisite funding being approved in the State budget."

AB 2043 (Arambula): (The text of the bill can be found at:
http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180AB2043

- Approximately 525 organizations have signed on to support this bill vs. a normal range of 40 – 50 supporters.
- There is language in the bill that indicates bill will only be implemented to the extent that funding is provided.
- Any cost that would occur would not be attached to county (as a state-mandated program at state/federal cost).
- It is acknowledged that there would be a significant cost associated with implementation of AB 2043, even though not to be picked up by the county.
    - As a result, CWDA et al are pursuing a budget appropriation through the state budget.
- With respect to "county flexibility," AB 2043 was modeled after Seneca's mobile response. (Contra Costa County has a contract with Seneca for its Mobile Response Team, through Health Services Department.)
    - The bill calls for counties to develop local plans for implementation and for DSS to develop guidance to counties based on stakeholder feedback that includes counties. So counties would have some flexibility in how to structure services locally.
- Estimates of potential volume:
    - In the year 2017, there were approximately 655 calls to the Contra Costa County Mobile Response Team (Seneca).
        - In answer to the Supervisors' question, there *are* face-to-face responses as well as phone-only.
        - We are not able to extrapolate from this an estimate of volume under AB 2043, but the 2017 figures provide a current order of magnitude.

AB 2083 (Cooley): (The text of the bill can be found at:
http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180AB2083

- There is language in the bill (as in AB 2034) that attends to the Prop 30 protections, meaning that the bill will only be implemented to the extent that funding is provided.
- AB 2083 does not have a high fiscal cost, but any cost that would occur, would not be attached to county (as a state-mandated program at state/federal cost).
- In answer to Supervisor Mitchoff's question: the MOU template would be provided by the State Interagency Team, modeled after what was adopted through the CCR State/County Team.

Recommendation(s)/Next Step(s):

CONSIDER recommending to the Board of Supervisors a position of "Support, if funded" for AB 2043 (Arambula): and "Support" for AB 2083 (Cooley) and sending to the Board for their consent.

Fiscal Impact (if any):

AB 2043: *(Fiscal impact on State)*

1) Estimated first-year costs of $15 million (GF) to DSS to establish the statewide hotline and implement mobile response services.

2) Estimated ongoing annual total costs of $30 million (GF) to DSS to maintain the system -- approximately $2.3 million to staff and administer the hotline, and $27.7 million for county mobile response teams. The total cost estimate assumes, once the system is established, at least 80% of county response services would be eligible for matching funds under the federal Medicaid program.

3) Costs of $159,000 (GF/federal funds) in FY 2018-19 and $225,000 (GF/federal funds) in FY 2019-20 and ongoing to the Department of Health Care Services (DHCS) for two additional positions.

(The bill's author submitted a budget request for a $15 million appropriation as an initial state investment in the Family Urgent Response System described in this bill.)

AB 2083:

1) Unknown onetime costs, likely less than $1 million (local funds/GF) statewide, for counties to develop and implement the required MOUs.

2) Unknown onetime costs, likely less than $1 million (GF), to the California Health and Human Services Agency and the SPI to establish the joint interagency resolution team and perform the required duties, including assisting counties with developing their MOUs, developing a multi-year plan, and reporting to the Legislature.

Attachments

No file(s) attached.

Contra Costa County Board of Supervisors

Subcommittee Report

LEGISLATION COMMITTEE **7.**

Meeting Date: 05/14/2018
Subject: AB 3087 (Kalra): State Health Care Cost, Quality, and Equity Commission
Submitted For: LEGISLATION COMMITTEE,
Department: County Administrator
Referral No.: 2018-17
Referral Name: AB 3087
Presenter: Patricia Tanquary **Contact:** L. DeLaney, 925-335-1097

Referral History:

AB 3087 (Kalra): State Health Care Cost, Quality, and Equity Commission, is a bill that establishes the Health Care Cost, Quality, and Equity Commission (Commission), to among other functions, control in-state health care costs and set the amounts accepted as payment by health plans, hospitals, physicians, physician groups, and other healthcare providers.

The Chief Executive Officer of the Contra Costa Health Plan, Patricia Tanquary, recommends that the Committee consider recommending an "Oppose unless amended" position on AB 3087 to the Board of Supervisors.

Author:	Ash Kalra (D-027)
Coauthor	Stone (D)
Title:	State Health Care Cost, Quality, and Equity Commission
Fiscal Committee:	no
Urgency Clause:	no
Introduced:	02/16/2018
Last Amend:	05/02/2018
Disposition:	Pending
Location:	Assembly Appropriations Committee
Summary:	Creates the State Health Care Cost, Quality, and Equity Commission, an independent state agency, to control in state health care costs and set the amounts accepted as payment by health plans, hospitals, physicians, and other health care providers. Provides that funding for the Commission would be provided from specified funds. Requires the Commission to annually determine the base amounts that health care entities are required to accept as full payment for health care service. Provides certain exemptions.

Referral Update:

The text of AB 3087 is available here:
http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180AB3087

According to the bill analysis (**Attachment A**), the author contends that while California has made major strides in providing access to health care and promoting quality care, the cost of health care remains unaffordable for many working Californians and is a significant burden among public and private employers. In California, health insurance premiums have continued to rise way past inflation, and the cost of which is putting a strain on state public funds being used to cover the cost of health care. Numerous reports have demonstrated that the costs health care in the U.S. are out-of-control, and hospital costs and physician services represent an overwhelming proportion of the projected premium dollar - 75% of the projected 2018 premium dollar.

The author notes that the reason the U.S. spends far more on health care than other nations is because of the prices. One thing all countries with universal health care have in common is that the government sets and regulates health care prices and controls overall costs throughout the system, including the commercial market. This bill addresses skyrocketing costs in California by establishing an independent Health Care Cost, Quality and Equity Commission to set reasonable base amounts that hospitals, doctors, and other providers of health care services can collect from public and private payers. For health plans, the Commission will also determine appropriate base amounts for premiums using an adjusted Medicare Advantage rate as the benchmark. Doing so will provide needed relief as all payers will be paying less for health care through lower premiums and cost-sharing without compromising on quality.

The author concludes that the high cost of health care is unsustainable and the state must take meaningful action to contain these costs.

According to the Alameda-Contra Costa Medical Association, "AB 3087 (Kalra) would establish an unelected commission of nine individuals to set physician and hospital rates for commercial health care services in California, while doing nothing to address chronically low Medicare and Medi-Cal reimbursement rates. The consequence if AB 3087 becomes law will be reduced access to care for the most vulnerable patients."

Attachment B includes letters in opposition from the East Bay Leadership Council, Kaiser, and the Alameda-Contra Costa Medical Association.

Recommendation(s)/Next Step(s):

CONSIDER recommending to the Board of Supervisors a position of "Oppose unless amended" on AB 3087.

Attachments

Attachment A: Bil Analysis

Date of Hearing: April 24, 2018

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
AB 3087 (Kalra) – As Amended April 17, 2018

SUBJECT: California Health Care Cost, Quality, and Equity Commission.

SUMMARY: Establishes the Health Care Cost, Quality, and Equity Commission (Commission), to among other functions, control in-state health care costs and set the amounts accepted as payment by health plans, hospitals, physicians, physician groups, and other healthcare providers. Specifically, **this bill**:

I. COMPOSITION/STRUCTURE OF THE COMMISSION

1) Establishes the Commission as a state agency that is an independent public entity that is not affiliated with an agency or department.

2) Establishes the membership of the Commission consisting of 11 members who are residents of California, and of which:
   a) Three are to be appointed by the Governor;
   b) Three are to be appointed by the Senate Committee on Rules;
   c) Three are to be appointed by the Speaker of the Assembly;
   d) The Secretary of California Health and Human Services or his or her designee to serve as a voting, ex officio member; and,
   e) A California Public Employees' Retirement System (CalPERS) representative to be designated by the CalPERS Board of Administration to serve at the pleasure of CalPERS Board of Administration as a voting, ex officio member.

3) Sets up the terms of office as follows:
   a) Members of the Commission, other than an ex officio member, are to be appointed for a term of six years;
   b) Appointments made by the Governor are subject to confirmation by the Senate;
   c) Members of the Commission are to serve until the appointment and qualification of a successor;
   d) Vacancies are to be filled by appointment for the unexpired term;
   e) The Commission is to elect a chairperson on an annual basis; and,
   f) Initial appointments are to be for staggered terms. Requires the Governor to appoint one member for two years, one member for four years, and one member for six years. Requires the Senate Committee on Rules and the Speaker of the Assembly to each appoint one member for one year and one member for three years.

4) Allows an individual appointed to the Commission to have more than one of the qualifications specified below, and requires that appointees to the Commission to be made as follows:
   a) One individual with demonstrated expertise in health care policy;
   b) One individual with demonstrated expertise in health care delivery;
   c) One health economist;
   d) One consumer advocate;
   e) One individual with demonstrated expertise in health care financing, including alternative payment methodologies;

f) One representative of a labor union organization who serves as a trustee of a trust fund organized under state or federal law;
g) One representative of an organization of employers with demonstrated expertise in health care purchasing;
h) One physician; and,
i) One individual with experience in hospital administration.

5) Requires each member of the Commission to have the responsibility and duty to meet the requirements of this bill and all applicable state and federal laws and regulations to serve the public interest of the public and private purchasers, payers, and providers of health care, and to protect the personal health information of health care consumers.

6) Requires the appointing authorities to consider the expertise of the current members of the Commission and make appointments to complement those members' expertise. Requires the appointing authorities to take into consideration the racial, ethnic, gender, and geographical diversity of the state so that the Commission's composition reflects the communities of California.

7) Prohibits the following:
   a) A member of the Commission or of the staff of the Commission from being employed by, a consultant to, a member of the board of directors of, affiliated with, or otherwise a representative of, a carrier or other insurer, an agent or broker, a pharmaceutical manufacturer, a health care provider, a health care facility, or a health clinic while serving on the Commission or on the staff of the Commission;
   b) A member of the Commission or of the staff of the Commission from being a member, a board member, or an employee of a trade association of carriers, pharmaceutical manufacturers, health care facilities, health clinics, or health care providers while serving on the Commission or on the staff of the Commission;
   c) A member of the Commission or of the staff of the Commission from being a health care provider unless he or she does not receive compensation for rendering services as a health care provider and does not have an ownership interest in a professional health care practice;
   d) A member of the Commission from engaging in ex parte communications with an individual or organization that may appeal to the Commission;
   e) A member of the Commission from making, participate in making, or attempting to use his or her official position to influence the making of a decision the Commissioner knows or has reason to know will have a reasonably foreseeable material financial effect, distinguishable from its effect on the public generally, on the Commissioner, on a member of his or her immediate family, or on either of the following:
      i) A source of income, other than gifts and loans by a commercial lending institution in the regular course of business on terms available to the public without regard to official status aggregating two hundred fifty dollars ($250) or more in value provided to, received by, or promised to the member within 12 months before the decision is made; or,
      ii) A business entity in which the member is a director, officer, partner, trustee, or employee, or holds a position of management.
   f) The Commission, a member of the Commission, or an officer or employee of the Commission shall from being held liable in a private capacity for, or on account of, an act performed or obligation entered into in an official capacity, when done in good faith, without intent to defraud, and in connection with the administration, management, or conduct or affairs related to the provisions of this bill.

8) Requires a member of the Commission to receive adequate compensation for his or her service on the Commission. Allows a member of the Commission to receive a per diem and reimbursement for travel and other necessary expenses while engaged in the performance of official duties of the Commission, as specified.

9) Requires the Commission to hire an executive director (ED) to organize, administer, and manage the operations of the Commission. Requires the ED to be exempt from civil service and to serve at the pleasure of the Commission.

10) Subjects the Commission to the Bagley-Keene Open Meeting Act but allows the Commission to hold closed sessions when considering matters related to litigation, personnel, and contracting.

II. PURPOSE OF THE COMMISSION

11) Establishes the following purposes of the Commission:
   a) To set the amounts accepted as payment by health plans, hospitals, physicians, physician groups, and other health care providers;
   b) To determine methods for state government to reduce the cost of prescription drugs and medical devices paid for by private purchasers in the commercial market;
   c) To control in-state health care costs in a manner intended to improve health care quality, improve health outcomes, and reduce health disparities for all Californians;
   d) To reduce price discrimination by health care providers among health care purchasers and the variation in prices paid to providers by private purchasers in the commercial market;
   e) To ensure payments to health care providers will permit them to provide medically necessary, effective, and efficient health care services in a manner that improves health outcomes, reduces health disparities, ensures there are an adequate number of providers to provide timely access to health care services for all Californians with commercial health coverage, and ensures a fair and reasonable return on investment to providers; and,
   f) To measure and reduce total health care expenditures per capita in the state.

12) States that it is not the purpose of the Commission to determine rates with respect to the Medi-Cal program or any other public health program.

III. ADVISORY COMMITTEE

13) Requires the Commission to convene an advisory committee composed of a diverse set of health care stakeholders with demonstrated expertise in private, commercial, or Medicare health care payments and financing, health care delivery, health care quality, health care workforce, population health, health equity, or a combination of these.
14) Requires the appointments to the advisory committee to be for a term of at least one year.

15) Requires the advisory committee to be made up of 15 members as follows:
   a) A representative of a health care service plan (health plan) , as specified, an insurer offering a policy of health insurance, as specified, or an association representing health plans;
   b) A representative of a licensed health facility, as specified;
   c) A representative of a clinic, as specified;
   d) A representative of an ambulatory surgery or other outpatient setting, as specified;
   e) A representative of a laboratory, radiology, or imaging center;
   f) A physician and surgeon who is licensed in California to deliver or furnish health care services;

g) A representative of a physician organization or medical group;
h) A representative of an organization of the employees of hospital or medical group providers licensed or certified to deliver health care services;
i) An expert in health information technology;
j) Any other provider of a health care service that is licensed, certified, or otherwise regulated by the state;
k) A representative of a self-insured or self-funded employer group health plan, multiemployer plan, or self-insured or self-funded joint labor-management trust that pays for health care services provided to beneficiaries;
l) A representative of CalPERS;
m) A representative of a large public sector purchaser of health care services;
n) A representative of a large private sector purchaser of health care services; and,
o) A representative of an organization representing health care consumers.

16) States that the purpose and duties of the advisory committee is to advise the Commission as follows:
a) Provide recommendations to the Commission regarding the establishment, implementation, and ongoing administration and evaluation of the Commission;
b) Advise the Commission on topics requested by the Commission; and,
c) Suggest questions and agenda items to the Commission for advisory committee consideration.

17) Requires the advisory committee to hold public meetings at least once every quarter, and solicit input on agendas and topics set by the Commission.

18) Requires meetings of the advisory committee to be subject to Bagley-Keene Open Meeting Act.

19) Requires a member of the advisory committee to recuse himself or herself from any matter directly affecting his or her interests or the interests of the entity or organization represented by the member.

20) Prohibits a member of the advisory committee from receiving per diem, travel expense reimbursement, or other expense reimbursement related to his or her service on the advisory committee.

IV. DUTIES OF THE COMMISSION

21) Requires the Commission to do the following:
a) Convene at least quarterly, or more frequently as required to fulfill its purpose under this bill;
b) Annually prepare a written report on the implementation and performance of the Commission during the preceding fiscal year, including, at a minimum, how funds were expended and the progress toward, and the achievement of, the requirements of this bill;
c) Respond to requests for additional information from the Legislature, including providing testimony and commenting on proposed state legislation or policy issues;
d) Maintain expenditures consistent with revenues;
e) Exercise all powers reasonably necessary to carry out and comply with the duties, responsibilities, and requirements of this bill; and,
f) Consult with the advisory committee stakeholders relevant to carrying out the activities of this bill.

22) Requires the report specified in 21) b) above to be publicly posted on the Commission's Internet Website; and, annually transmitted to the Legislature and the Governor.

23) Authorizes the Commission to do the following:

a) Enter into contracts;
b) Sue and be sued;
c) Receive and accept gifts, grants, or donations of moneys from an agency of the United States, an agency of the state, and a municipality, county, or other political subdivision of the state;
d) Receive and accept gifts, grants, or donations from individuals, associations, private foundations, and corporations, in compliance with the conflict of interest provisions to be adopted by the Commission at a public meeting;
e) Adopt rules and regulations, as necessary. Authorizes adoption of emergency regulations until January 1, 2022, as specified;
f) Share information with relevant state departments necessary for the administration of the Commission; and,
g) Employ necessary staff.

24) Requires the Commission to hire a chief fiscal officer, a chief operations officer, a chief technology and information officer, a general counsel, and other key executive positions, who are exempt from civil service.

25) Requires the Commission to set the salaries for the exempt positions specified in 24) above and the ED in amounts that are reasonably necessary to attract and retain individuals of superior qualifications. Requires the salaries to be published by the Commission in the Commission's annual budget. States that the positions of the ED and those described in 24) above are not to be subject to provisions of the Government Code or the Public Contract Code and, solely for the purpose of determining the salaries for those positions, the Commission is not to be considered a state agency or public entity.

26) Requires the Commission's annual budget to be posted on the Internet Website of the Commission.

27) Requires the Commission, in determining the salaries in 24) above, to cause to be conducted, through the use of independent outside advisors, salary surveys (surveys) of both of the following:
a) Other state and federal health care Commissions that are most comparable to the Commission; and,
b) Other relevant labor pools.

28) Requires the salaries established by the Commission in 25) above to not exceed the highest comparable salary for a position of that type, as determined by the surveys.

29) Requires the Department of Human Resources to review the methodology used in the surveys.

30) Prohibits the Commission from being subject to licensure or regulation by the Department of Insurance (CDI) or the Department of Managed Health Care (DMHC).

V. DEFINITION OF TERMS

31) Defines the following terms:
a) Adjusted amount is the maximum amount of payment approved by the Commission after the final decision on an appeal pursuant to this bill that a health care entity may require from a purchaser as payment in full for health care services, in addition to applicable cost sharing;
b) Applicable cost sharing is the copayments, deductibles, coinsurance, and any other share of cost for services that is permitted consistent with state law and regulations or federal law, rules, and guidance;

c) Base amount is the amount of payment for health care services as a percentage of Medicare rates that a health care entity may require from a purchaser as payment in full for health care services, in addition to any applicable cost sharing;
d) Commercial health coverage is coverage that is paid for by individual consumers for their own benefit, employers for the benefit of employees and dependents, employee benefit plans for the benefit of plan participants and their dependents, or another individual or group health plan. Excludes from the definition of commercial health coverage Medicare, Medi-Cal, the Indian Health Service, the Federal Employees Health Benefit Program, or TRICARE;
e) A health care entity as the following:
    i) A health plan or an insurer offering a policy of health insurance as specified;
    ii) A licensed health facility, as specified;
    iii) A clinic, as specified;
    iv) An ambulatory surgery or other outpatient setting, as specified;
    v) A laboratory, radiology, or imaging center that is required to be licensed or certified by the state;
    vi) A physician and surgeon or other professional who is licensed in California to deliver or furnish health care services and who is a member of a health profession in which some professionals bill independently for their services;
    vii) A physician organization or medical group; or,
    viii) Any other provider of a health care service that is licensed, certified, or otherwise regulated by the state and that bills separately or independently for that service.
f) A Health care provider as a health care entity as specified in e) ii) to e) viii) above;
g) Health care services as covered benefits, including essential health benefits (EHBs), as specified, and any other covered benefits as provided in the evidence of coverage or plan documents provided by a health plan, insurer, or self-insured plan;
h) Noncontracting physician or other noncontracting health professional as a physician or health professional who is not contracted with a state-licensed health plan or a health insurer licensed by the state; and,
i) Purchasers as consumers who purchase health coverage as individuals and employers, plans, and trust funds that purchase health coverage or pay for health care benefits on the behalf of their employees, dependents, or plan members.

VI. EXCEPTIONS TO THIS BILL

32) States that this bill does not apply to the following:
    a) A Medi-Cal managed care (MCMC) plan or an entity that enters into a contract with the State Department of Health Care Services (DHCS); nor,
    b) Individuals receiving coverage through the Medicare program or any other federal program, including the Indian Health Service, TRICARE, the Federal Employees Health Benefit Program, or any other federal program providing health care services.

33) States that the amounts paid for services under this bill do not constitute a health care provider's uniform, published, prevailing, or customary charges and are not to be used for purposes of a payment limit under the federal Medicare Program, the Medi-Cal program, or any other federal or state-financed health care program.

34) States that this bill is not intended to act upon, govern, impose obligations upon, or otherwise regulate employee welfare benefit plans regulated by the Employee Retirement Income Security Act (ERISA) of 1974. Provides that this bill does not prohibit those plans from accessing the rates set by the Commission for regulated health care entities.

VII. PURCHASER PARTICIPATION PROGRAM

35) Requires the Commission, on or before July 1, 2019, to adopt regulations to establish the Purchaser Participation Program, which allows for the ED to award reasonable advocacy and witness fees to a person or organization that demonstrates that the person or organization represents the interests of purchasers and has made a substantial contribution on behalf of purchasers to the adoption of a regulation or to an order or decision made by the ED if the order or decision has the potential to impact a significant number of consumers.

36) Includes in the regulations adopted by the Commission specifications for eligibility of participation, rates of compensation, and procedures for seeking compensation. Requires the regulations to require that the person or organization demonstrate a record of advocacy on behalf of health care consumers in administrative or legislative proceedings in order to determine whether the person or organization represents the interests of purchasers.

37) Applies the above provisions to all proceedings of the Commission, including individual rate cases.

38) Requires the fees awarded to be considered costs and expenses, and to be paid from the assessments made under this bill.

39) Requires the Commission to report the following information on or before March 1, 2020, and annually thereafter:
   a) The amount of reasonable advocacy and witness fees awarded each fiscal year;
   b) The individuals or organizations to whom advocacy and witness fees were awarded; and,
   c) The orders, decisions, and regulations pursuant to which the advocacy and witness fees were awarded.

40) Requires the report in 39) above to be publicly posted on the Commission's Internet Website, and annually transmitted to the appropriate policy and fiscal committees of the Legislature.

VIII. FUNDING OF THE COMMISSION

41) Requires funding for the actual and necessary expenses of the Commission to be provided, from transfers of moneys from the Managed Care Fund and the Insurance Fund;

42) Requires the share of funding from the Managed Care Fund to be based on the number of covered lives in the state that are covered under plans regulated by the DMHC, including covered lives under MCMC, as determined by DMHC, in proportion to the total number of covered lives in the state.

43) Requires the share of funding from the Insurance Fund to be based on the number of covered lives in the state that are covered under health insurance policies and benefit plans regulated by CDI, including covered lives under Medicare supplement plans, as determined by CDI, in proportion to the total number of covered lives in the state.

44) Requires the allocation of the share of funding from the funds described in 41) above to be determined annually during the budget process.

IX. BASE AMOUNT

45) Requires the Commission, beginning July 1, 2019, and annually thereafter, to establish base amounts that health care entities accept as payment in full for health care services, in addition to applicable cost sharing. Requires the base amount to apply to a contract with a health care entity that was issued, amended, or renewed on or after the effective date of the base amount. Requires the Commission to determine the effective date or dates of base amounts, but no earlier than July 1, 2019.

46) Requires the Commission, on or before July 1, 2019, to adopt regulations governing the annual determination of base amounts. Requires the Commission, in its determination of the base amounts, to allow the submission of written comments and testimony by health care entities and purchasers.

47) Requires the annual determination of base amounts to be exempt from the Administrative Procedure Act.

48) Requires the Commission to annually determine the percentage of Medicare rates used to determine the base amount, as follows:

a) For *health care providers*, the percentage determined by the Commission to be not lower than 100% of Medicare rates, and may exceed Medicare rates; requires the base amounts to be a percentage of the rate that Medicare reimburses for the same or similar services in the general geographic region in which the services were rendered, unless those services are provided on a contractual basis to a health plan or health insurer licensed by the state; and,
b) For a *health plan contract or a policy of health insurance*, the base amount to be a percentage of the capitated rate a health plan receives for Medicare Advantage for the county where the enrollee or insured resides, adjusted for all of the following:
   i) Age;
   ii) Risk mix;
   iii) Differences in cost sharing between the Medicare Advantage plan and the coverage offered by the health plan or health insurer; and,
   iv) Other actuarial factors permissible under state and federal law.

49) Requires the Commission to take into account all of the following in determining the base amounts:
   a) Evidence of the financial status of hospitals, other health care providers, and Medicare Advantage plans, and the compensation of physicians and other health professionals in California. Requires the Commission to consider whether or not the health care entity is receiving a fair return on investment and avoidance of confiscatory results;
   b) Changes in state or federal laws that result in a change in costs;
   c) Reasonable increases in labor costs, including salaries and benefits, and changes in collective bargaining agreements or prevailing wage;
   d) Reasonable increases in capital investments, including those associated with compliance with state or federal law; and,
   e) Changes in the delivery of care that require adjustments in rates, such as the development of new modalities of care or new systems of care.

50) Authorizes the Commission to allow different percentages of Medicare rates to be used for different health care entities, including different percentages for Medicare Advantage than for the amounts paid to health care providers.

51) Allows a health plan or health insurer to negotiate contracted rates with contracting health providers that are not based on the Medicare rates as provided by this bill.

52) Requires the Commission to do the following:
   a) Establish a process for developing base amounts for health care services not currently reimbursed by Medicare or Medicare Advantage;
   b) Establish a process for determining reimbursement rates for health care services infrequently reimbursed by Medicare or Medicare Advantage and to include, at a minimum, pediatrics, obstetrics, and gynecology;
   c) Determine whether or not to include or alter Medicare rating factors, such as Medicare disproportionate share hospital rates, graduate medical education, readmission penalties, and other added rates as Medicare may allow. States that until the Commission makes such determination, the base amount will not include those factors.
   d) Review and adjust overall rates or specific rates to maintain the workforce necessary to deliver quality, equitable health care throughout the state, and allows the Commission make adjustments to ensure access to underserved populations throughout the state;
   e) Review the base amounts annually to ensure that the amounts are sufficient to ensure all of the following:
      i) The financial solvency requirements under state law for each of the following:
         (1) Health plans;
         (2) Insurers offering policies of health insurance; and,
         (3) Risk-bearing organizations.
      ii) A fair return on investment for the health care entity;
      iii) Avoidance of confiscatory results;
      iv) Improvements in health outcomes;
      v) Improvements in health disparities and reductions in health system costs consistent with this bill; and,
      vi) Availability and accessibility of health care services, including compliance with state requirements regarding network adequacy, timely access, and language access.
   f) Separately consider the impact of the base amounts in underserved areas, including rural areas determined to be underserved in accordance with state and federal requirements. Allows the Commission, to mitigate the impact of the base amounts on the availability and accessibility of health care services in underserved areas, to adjust the base amounts for services provided in those areas.

53) Authorizes the Commission, in determining base amounts, to take into account the reliance of the category of hospital or health professional on reimbursement by the Medi-Cal program, including supplemental Medi-Cal rates, such as disproportionate share hospital payments, intergovernmental transfers, prospective payment system rates for clinics, reimbursement based on quality assurance fees, or other supplement Medi-Cal rates that the provider receives.

54) Authorizes the Commission, if it determines that the Medicare reimbursement system has substantially changed and no longer serves the interests of Californians, to make recommendations to the Governor and the Legislature to ensure that the Commission continues to fulfill its purpose.

X. NONCONTRACTING PHYSICIANS/NONCONTRACTING PROVIDERS

55) Requires, to develop appropriate base amounts for noncontracting physicians and other noncontracting health professionals, health plans and health insurers to provide to the Commission the average contracted amount for the same or similar services in the general geographic regions in which the services were rendered for the three calendar years before the effective date of this bill.

56) Defines average contracted rate as the average of the contracted commercial rates paid by the health plan, delegated health entity, or health insurer for the same or similar services in the geographic region.

57) Provides that until the data submitted pursuant to 55) above is available to the Commission, the Commission shall not set a base amount for noncontracting physicians and other noncontracting health professionals.

58) Requires the Commission, to determine the base amounts for noncontracting physicians and other noncontracting health professionals, to take into account the commercial contracted rates paid in the three prior calendar years.

59) Provides that the provisions relating to noncontracting physicians do not apply to physicians and other health professionals contracting with health plans or health insurers.

60) States that until the Commission determines the base amounts for noncontracting physicians and other noncontracting health professionals, a physician or health professional who does not contract with a health plan or health insurer is not subject to the base amount.

XI. INTENT REGARDING THE MEDI-CAL PROGRAM

61) States the intent of the Legislature to better align the financing of the Medi-Cal program, including both the fee-for-service (FFS) program and MCMC, with Medicare rates.

62) Specifies the intent of the Legislature that savings to the General Fund (GF) from lower health care costs for public employers as a result of this bill to be directed, upon appropriation by the Legislature, to the Steven M. Thompson Physician Corps Loan Repayment Program, the Song-Brown Healthcare Workforce Training Programs, the Health Professions Education Fund, and other programs intended to recruit and retain health professionals in underserved areas.

63) Requires, beginning October 1, 2020, and on or before October 1 annually thereafter, the Commission to estimate the savings to the GF from lower health care costs paid by public employers, including the state and local governments, as a result of this bill, and to report the estimated savings to the Department of Finance (DOF) and the Legislature.

64) Requires DOF to provide an estimate of the cost to increase reimbursement rates for physicians and other health care providers to be comparable to Medicare, taking into account the differences in populations served. Requires DOF to include in its estimate an analysis of how much of the cost would be provided through federal financial participation and how much could be paid out of the estimated savings to the GF from lower health costs for public employers.

XII. APPEAL PROCESS

65) Requires the Commission, on or before July 1, 2019, to establish an appeals process for the purpose of considering adjustments to the base amounts to be paid to health care providers.

66) Requires the Commission to establish by regulation the following:
   a) Uniform written procedures for notice and the submission, receipt, processing, and consideration of appeals; and,
   b) Criteria for considering and making decisions on appeals to the base amount.

67) Requires decisions on appeals to be rendered within six months of the filing of an appeal. Specifies that a filing is not considered complete until the entity that is appealing has produced the documentation reasonably required by the Commission.

68) Requires a health care entity filing an appeal to certify that it has a good faith basis for pursuing the appeal and to identify the basis of the appeal pursuant to the specific factor/s enumerated in 69) below.

69) Requires the Commission to consider an appeal of the base amounts, filed by a health care entity, based on the following:
   a) The overall financial condition of the health care entity;
   b) A fair return on investment by a health care entity;
   c) Avoidance of confiscatory results;
   d) Risks to the ongoing operation of the health care entity and its financial solvency, if financial solvency requirements are imposed by law;
   e) Justifiable differences in costs among health care entities, such as providing a service not available from other providers in the region, or the need for health care services in rural areas with a shortage of health professionals or medically underserved areas and populations;
   f) Factors that led to increased costs for the health care entity that can reasonably be considered to be unanticipated and out of the control of the entity. Includes, but is not limited to the following factors:
      i) Natural disasters;
      ii) Outbreaks of epidemics or infectious diseases;
      iii) Unanticipated facility or equipment repairs purchases;
      iv) Unanticipated increases in a share of low-income, Medi-Cal, or uninsured populations; and,
      v) Significant and unanticipated increases in pharmaceutical or medical device prices.
   g) Changes in state or federal laws that result in a change in costs;
   h) Reasonable increases in labor costs, including salaries and benefits, and changes in collective bargaining agreements, prevailing wage, or local law;
   i) Reasonable increases in capital investments, including those associated with compliance with state or federal law; and,
   j) Changes in the delivery of care that require adjustments in rates, such as the development of new modalities of care or new systems of care.

70) Requires the base amount set by the Commission to be paid to the health care entity to stay in effect during the appeal process, subject to interim relief provisions.

71) Gives the Commission the power to grant *interim relief* based on fairness. Requires the Commission to develop regulations governing interim relief. Requires the Commission to establish uniform written procedures for the submission, processing, and consideration of an interim relief appeal by a health care entity. Requires a decision on interim relief to be granted within one month of the filing of an interim relief appeal. Requires a health care entity to certify in its interim relief appeal that the request is made on the basis that the challenged amount is arbitrary and capricious, or that the health care entity has experienced a bona fide emergency based on unanticipated costs or costs outside the control of the entity, including those in 69) f) above.

72) Authorizes the Commission to delegate the conduct of a hearing to an administrative law judge (ALJ), who will issue a proposed decision with findings of fact and conclusions of law.

73) Authorizes the ALJ to hold evidentiary hearings and requires the ALJ to issue a proposed decision with findings of fact and conclusions of law, including a recommended adjusted amount, within four months of the filing of the appeal.

74) Authorizes, within 30 days of receipt of the proposed decision by the ALJ, the Commission to approve, disapprove, or modify the decision, and requires the Commission to issue a final decision with an adjusted amount for the appealing health care entity.

75) Requires a final determination by the Commission to be subject to judicial review, as specified.

XIII. DATA COLLECTION

76) Grants the Commission the power to obtain information that is necessary to its deliberations.

77) Requires the Commission to receive the following information from the following entities:
   a) Information regarding facilities, workforce, and prescription drug prices from the Office of Statewide Health Planning and Development (OSHPD);
   b) Information regarding rate review and other information relevant to timely access to care, adequacy of network, and medical surveys from DMHC and CDI; and,
   c) Information regarding licensed health professionals from the Department of Consumer Affairs, the Medical Board of California, and other health profession licensing boards.

78) Requires the Commission to establish protocols to receive the information specified in 77) above.

79) Authorizes the Commission to require a health care entity or entities to provide information to allow the Commission to fulfill its obligations under this bill.

XIV. INFORMATION SUBMITTED TO THE COMMISSION

80) Requires all information submitted under this bill to be made publicly available by the Commission.

81) Prohibits disclosure of the following:
   a) The contracted rates between a health plan and a provider;
   b) The contracted rates between a health plan and a large group; or,
   c) Information provided to a large group purchaser, as specified.

82) Prohibits disclosure by the health plan of the contracted rates between a health plan and a provider to a large group purchaser, as specified.

83) Requires all information submitted to the Commission to be submitted electronically to facilitate review, as specified.

84) Requires the Commission to, at a minimum, make the following information readily available to the public on its Internet Website, in plain language and in a manner and format specified by the Commission, with the exceptions of the information specified in 81) above:
   a) Justifications for an appeal, including all supporting information and documentation;
   b) Information on pending appeals and final decisions on appeals;
   c) A plain language summary of the reasons for the determination regarding the appeal; and,

d) Information on the base amounts determined by the Commission, including the percentages and factors taken into account to determine the base amount.

85) Requires the information posted to the Commission's Internet Website under 84) above to be made public for 60 days before the hearing of an appeal.

XV. CONSUMER PROTECTIONS

86) Prohibits an individual from owing a health care provider an amount other than the applicable cost sharing that is otherwise permitted by law.

87) Prohibits a healthcare provider, for a service subject to this bill, from billing or collecting an amount from an individual other than the applicable cost sharing.

88) Authorizes, if a service is not a covered benefit, the health care provider to bill the individual and to collect the base amount from that individual. States that if the Commission has not determined the base amount for a particular service that is not a covered benefit, a health care provider may determine an appropriate amount for the service and bill the individual.

89) Prohibits, if an individual does not have health coverage, the individual from paying more than the base or adjusted amount determined under this bill.

XVI. GLOBAL CAP

90) Requires the Commission to obtain the information necessary to determine total health care expenditures and to set a global cap for total health care expenditures based on gross state product.

91) Requires the Commission to use existing data sources to determine total health care expenditures to the extent publicly available. Specifies that if appropriate data sources do not exist, the Commission to require sufficient data to be collected to allow it to measure the cost of health care, as well as impacts on quality, equity, and workforce adequacy.

92) Requires the Commission to identify the reasons why there has been a failure to achieve the global cap and may order corrective action in order to reduce expenditures to stay above the global growth cap.

93) Requires the Commission to report at least annually on the total health care expenditures and the global growth cap. Requires the Commission to vote on that report at a regularly scheduled meeting of the Commission; and requires the report to:
a) Be publicly posted on the Commission's Internet Website; and,
b) Be annually transmitted to the Legislature and the Governor.

94) Requires the Commission, in determining the global growth cap for total health care expenditures, to take into account the adequacy of funding for the Medi-Cal program, including both the FFS program and the MCMC program. Requires the Commission to consider the impact on quality and equity of the adequacy of funding the Medi-Cal program.

XIV. SEVERABILITY

95) Includes a severability clause and states that if a section, subdivision, sentence, clause, or phrase of this bill, or its application to a person or circumstances, is held invalid, the validity of the remainder of bill, or the application of that provision to other persons or circumstances, is not to be affected.

EXISTING LAW:

1) Establishes the federal ERISA, to among other provisions, prohibits state from enforcing laws related to private-sector employee health benefit plans.

2) Establishes the federal Patient Protection and Affordable Care Act (ACA), which enacts various health care coverage market reforms including the availability of health insurance exchanges (exchanges) and new individual and small group products offered on and off the exchanges beginning 2014.

3) Requires health plans and health insurers providing health coverage in the individual and small group markets to cover, at a minimum, EHBs, including the ten EHB benefit categories in the ACA, as specified.

4) Establishes, in state government, the California Health Benefits Exchange, referred to as Covered California, as an independent public entity not affiliated with an agency or department, and requires the Exchange to compare and make available through selective contracting health insurance for individual and small business purchasers as authorized under the ACA. Specifies the powers and duties of the board governing the Exchange, and requires the board to facilitate the purchase of qualified health plans though the Exchange by qualified individuals and small employers.

5) Establishes the DMHC to regulate health plans and the CDI to regulate health insurers.

6) Requires contracts between providers and health plans to be in writing and prohibits, except for applicable copayments and deductibles, a contracted provider from invoicing or balance billing a health plan's enrollee for the difference between the provider's billed charges and the reimbursement paid by the health plan or the health plan's capitated provider for any covered benefit.

7) Prohibits a provider, in the event that a contract has not been reduced to writing, or does not contain the prohibition above, from collecting or attempting to collect from the subscriber or enrollee sums owed by the health plan. Prohibits a contracting provider, agent, trustee or assignee from taking action at law against a subscriber or enrollee to collect sums owed by the health plan.

5) Requires health plans and health insurers to file specified rate information with DMHC or CDI, as applicable, for health plan contracts or health insurance policies in the individual or small group markets and in the large group market.

6) Requires, for large group health plan contracts and health insurance policies, carriers to file with DMHC or CDI the weighted average rate increase for all large group benefit designs during the 12-month period ending January 1 of the following calendar year, and to also disclose specified information for the aggregate rate information for the large group market.

7) Requires DMHC to develop and adopt regulations to ensure that enrollees have access to health care services in a timely manner and consider specified indicators of timeliness of access to care.

8) Requires CDI to promulgate regulations to ensure that insureds have the opportunity to access needed health care services in a timely manner and ensure adequacy of the number and locations of facilities and providers and consider the regulations adopted by DMHC.

9) Requires DMHC to oversee the fiscal solvency of health plans and the risk-bearing organizations that contract with those plans. Requires health plans to have and maintain a tangible net equity, as specified.

10) Requires clinics such as primary care clinics, specialty clinics, chronic dialysis clinics and alternative birth centers to be licensed by the Department of Public Health (DPH).

11) Requires hospitals such as general acute care hospitals (GACHs), and clinical laboratories to be licensed by DPH.

12) Establishes OSHPD as the single state agency responsible for collecting specified health facility and clinic data for use by all agencies. Requires hospitals to make and file with OSHPD certain specified reports, including annual financial reports that includes a detailed income statement, balance sheet, statements of revenue and expenses, and supporting schedules.

13) Establishes the Medi-Cal program, administered by DHCS, under which qualified low-income persons receive health care benefits and, in part, governed and funded by federal Medicaid program provisions.

14) Makes, under federal law, Medicare data available for the evaluation of the performance of providers of services and suppliers, to qualified entities, defined as a public or private entity that is qualified as determined by the Secretary of the federal Department of Health and Human Services (HHS), to use to evaluate the performance of providers of services and suppliers on measures of quality, efficiency, effectiveness, and resource use, and applies other requirements to qualified entities as the HHS Secretary may specify, such as ensuring security of data.

15) Provides for the licensure and regulation of various healing arts professions, including, but not limited to, physicians and surgeons, by various boards within the Department of Consumer Affairs.

FISCAL EFFECT: This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, while California has made major strides in providing access to health care and promoting quality care, the cost of health care remains unaffordable for many working Californians and is a significant burden among public and private employers. In California, health insurance premiums have continued to rise way past inflation, and the cost of which is putting a strain on state public funds being used to cover the cost of health care. Numerous reports have demonstrated that the costs health care in the U.S. are out-of-control, and hospital costs and physician services represent an overwhelming proportion of the projected premium dollar – 75% of the projected 2018 premium dollar.

   The author notes that the reason the U.S. spends far more on health care than other nations is

because of the prices. One thing all countries with universal health care have in common is that the government sets and regulates health care prices and controls overall costs throughout the system, including the commercial market. This bill addresses skyrocketing costs in California by establishing an independent Health Care Cost, Quality and Equity Commission to set reasonable base amounts that hospitals, doctors, and other providers of health care services can collect from public and private payers. For health plans, the Commission will also determine appropriate base amounts for premiums using an adjusted Medicare Advantage rate as the benchmark. Doing so will provide needed relief as all payers will be paying less for health care through lower premiums and cost-sharing without compromising on quality.

The author concludes that the high cost of health care is unsustainable and the state must take meaningful action to contain these costs. This bill gets California along a path towards more equitable health care for all, not just the providers, and there are many facets of the Commission to ensure providers can still provide quality care to millions of Californians and also address serious health disparities that are allowed to unaddressed under our current system. As California continues to lead the nation in building toward a system that provides quality, affordable health care to all, prices must be controlled now.

2) BACKGROUND.

a) Overview of California's healthcare landscape. Californians obtain their health care in an array of settings. Sources of coverage impact where Californians obtain health care, as do plan contracting requirements and provider payment arrangements.

i) Private insurance (employer and individual) is the largest source of coverage. Employer-sponsored coverage insures nearly 43% or about 17.5 million Californians. About 2. 3 million Californians are enrolled in the individual market. Six million Californians with employer-sponsored coverage are in self-insured arrangements subject to ERISA where states have limited regulatory oversight. Under ERISA, states cannot directly regulate private employer health insurance arrangements nor impose a requirement that private employers offer or pay for health insurance.

ii) Medi-Cal is the next source of coverage insuring about 14 million residents, at a cost of $100 billion in total funds ($19.6 billion GF). Medi-Cal is the fastest growing source of coverage, and is administered by DHCS through two types of delivery systems: managed care and FFS. Approximately 79% of the 14 million Medi-Cal beneficiaries receive care through MCMC plans. There are six models of managed care: (1) The county organized health systems (COHS) is available in 22 counties and as of December 2016 there were 2.2 million Medi-Cal beneficiaries enrolled in COHS plans; (2) Under the two-plan model, 14 counties have one commercial and one county-organized local initiative covering 6.9 million beneficiaries; (3) Two counties operate in a geographic managed care (GMC) models (San Diego and Sacramento) where four or five plans participate. As of December 2016, 1.2 million Medi-Cal beneficiaries where enrolled in GMC models; (4) In 18 more rural counties, there are two commercial plans serving over 300,000 beneficiaries; (5) In Imperial county, there are two commercial plans serving over 75,000 Medi-Cal beneficiaries; and, (6) In San Benito, there is one commercial plan and beneficiaries can choose either the plan or Medi-Cal FFS, and almost 84,000 enrollees are enrolled in the commercial plan. California embraced the Medicaid expansion available under the ACA.

In 2016, the state expanded Medi-Cal to all children, regardless of immigration status, using only state funds.

iii) Medicare covers about six million Californians. In 2016, 3.4 million Californians were enrolled in traditional Medicare (FFS) and 2.5 million were enrolled in Medicare Advantage plans, where beneficiaries have the option to receive their Medicare benefits through private health plans, mainly health maintenance organizations (HMOs). Under Medicare Advantage, plans are paid a capitated (per enrollee) amount to provide Part A and Part B benefits (collectively hospital inpatient services, skilled nursing, home health, physician payments, and hospital outpatient services). Medicare Advantage makes a separate payment to plans for providing prescription drug benefits (Part D).

California's implementation of the ACA cut the uninsured rate in half to 7.1% or about 3 million today. The majority of the remaining uninsured, about 1.8 million, are not eligible for coverage programs due to immigration status.

b) Delivery system. California has a long history of heavy reliance on managed care arrangements, including incentives or restrictions related to provider network, in both public and private health plans. More than 60 % of insured Californians are enrolled in HMO plans, a higher share than most other states. Among California Medicare enrollees, 41% are in Medicare Advantage managed care plans, and approximately 80% of Medi-Cal enrollees are in managed care plans.

i) Health plans/health insurers. Health plans are responsible for health care provider contracting and payment and, to varying extents these plan contracts can establish rules and incentives for providers to meet quality standards and achieve positive health outcomes. The state's three largest insurance carriers by total enrollment are Kaiser, Anthem and Blue Shield of California. Other plans, including MCMC plans in many California counties, also provide coverage for millions of Californians. The share of enrollment by market segment (individual, small group, large group, Medi-Cal and Medicare and administrative services only for self-insured arrangements) varies considerably across insurers.

Health insurers collect premiums from purchasers and establish contracts with providers to deliver care to enrollees. Plans differ in the composition of provider networks: Kaiser contracts exclusively with Permanente physicians and offers the same providers to all enrollees. Other plans develop networks that vary by product and market segment. Health insurers perform a variety of functions, and the functions vary significantly across channels of coverage – that is, health plan functions in the individual and small group market are different from their functions in the large group market, and different again from their functions in the Medicare and Medi-Cal markets. For individuals and small groups, a key function is the aggregation of risk. For large groups, the main functions of health plans are provider contracting and payment, member services, and working with (and sometimes against) providers to reduce the provision of low value care and increase quality and efficiency. Some California health insurance carriers reimburse providers via full or partial capitation arrangements that reduce or eliminate provider incentives to increase the volume of services. Although FFS remains the most common method of paying providers, California health plans are increasingly tying providers' financial risk more explicitly to accountability for quality and outcomes.

ii) **Physicians**. At the frontline of health care delivery are health care providers, which include physicians and surgeons, and other allied healing arts practitioners. Given the size, population and geographic diversity of the state, most areas in California are experiencing provider shortages, both in primary care and specialty care, but the severity varies by region. Additionally, many areas of California are also designated as dental shortage areas. Currently, there are about 131,000 physicians and surgeons licensed by the Medical Board of California. However, only 80% of physicians with active licenses provided patient care for 20 or more hours per week. Physician supply varied by region. The Greater Bay Area was the only region that met the recommended supply of primary care physicians. The Inland Empire, San Joaquin Valley, and Northern and Sierra Counties all fell short of the recommended supply of specialists. While the recommended supply is 60 to 80 per 100,000 population, California's statewide average is 50 per 100,000. For specialists, the recommended supply is 85 to 105 per 100,000 but California's statewide average is 104 physicians per 100,000 population.

iii) **Hospitals**. Hospitals serve an important role in the delivery of healthcare services. There are approximately 386 hospitals throughout the state. Urban areas generally have a higher concentration of facilities, while residents in rural areas of the state may have to travel for hours to reach the closest hospital. Most hospitals are GACHs which provide eight basic services: medical; nursing; surgical; anesthesia; laboratory; radiology; pharmacy; and, dietary services. In addition to the eight basic services, GACHs can be approved by the DPH to offer special services, including but not limited to the following: radiation therapy department; burn center; emergency center; hemodialysis center; psychiatric; intensive care newborn nursery; cardiac surgery; cardiac catheterization laboratory; renal transplant; and, other special services. More rural areas of the state lack access to specialty services.

California also has 21 public health care systems, which include county-affiliated systems and five University of California academic medical centers. Public health care systems operate in 15 counties and also operate more than 200 outpatient clinics. Additionally, there are 79 healthcare districts in California that operate hospitals, and skilled nursing facilities among other facilities.

iv) **Clinics**. Community clinics and health centers also play a critical role in assuring access to health care for Californians, especially those who are uninsured or who experience other barriers to care. Community clinics and health centers are nonprofit, tax-exempt clinics that are licensed as community or free clinics, and provide services to patients on a sliding fee scale basis or, in the case of free clinics, at no charge to the patients. These include federally designated community health centers, migrant health centers, rural health centers, and frontier health centers. California is home to nearly 1,000 community clinics serving more than 5.6 million patients (or one in seven Californians) annually through over 17 million patient encounters. More than 50% of these patients are Hispanic and 43% speak a primary language other than English.

c) **Healthcare Spending**. According to the Centers for Medicare and Medicaid Services (CMS) National Health Expenditures Highlights, in 2016, U.S. health care spending increased 4.3% or 1.5 percentage points faster than the growth in the gross domestic product (GDP) and reached $3.3 trillion, or $10,348 per person. According to the Commonwealth Fund, the United States spends far more on health care than other high-income countries, with spending levels that rose continuously over the past three decades. However, the U.S. population has poorer health than

other countries. The Commonwealth Fund study points out that the U.S. ranks last in access, equity, and health care outcomes, and next to last in administrative efficiency, as reported by patients and providers. Only in care process does the U.S. perform better, ranking fifth among 11 industrialized countries.

Total health care spending across the state of California, from all sources, totals about $400 billion. Of this total, more than half comes from public sources of which the largest shares are Medicare ($75 billion); Medi-Cal (more than $100 billion); and federal ACA subsidies through Covered California ($6 billion). Private spending is primarily through employer-sponsored insurance premiums (ESI) ($100 billion to $150 billion). In addition to the portion of the $100 billion to $150 billion in ESI premiums that is paid by employees, consumers pay $10 billion for premiums for individual insurance and $25 billion to $35 billion in out-of-pocket spending. Federal and state tax law allows payments toward ESI to be excluded from employees' taxable income. In California, this exclusion accounts for foregone revenues between $40 billion and $50 billion. About 75% of this indirect tax benefit comes from the federal government.

According to the California Health Care Foundation (CHCF) the healthcare per capita spending in California is $7,549 and reached $292 billion in 2016. From 2009 to 2014, spending growth averaged 4.9% per year in total and 4.0% per capita. This was faster than average US spending growth (3.9% total health spending, 3.1% per capita) during the same period. It also exceeded California's average annual five-year growth in GDP (4.2%), consumer price index (1.9%), and median wages (1.0%). CHCF points out that overall per capita spending for California was about $500 per person lower than the U.S. average. Medicaid spending differences per enrollee were the most dramatic, with annual California spending per enrollee nearly $1,500 (21%) less than the U.S. In contrast, California Medicare and private health insurance spending per enrollee were both higher than the US average ($847, or 8% higher, for Medicare; $184, or 4% higher, for private health insurance).

CHCF points out that overall, hospital care accounts for the largest source of healthcare spending (36%); followed by physician and clinical services (26%); prescription drugs (13%); and, nursing home care (5%).

d) Variation in Provider Payments. At an informational hearing conducted by the Select Committee on Health Care Delivery Systems and Universal Coverage (Select Committee) on January 17, 2018, a description of the variation in provider payments by public and private payers was presented. The federal government sets the provider rates for Medicare and states sets physician payment rates and negotiates rates with hospitals for Medicaid. In the commercial market, payers and providers negotiate contracts to determine rates and network inclusion. According to the presentation, private insurers reimburse hospitals about 75% more than Medicare and Medicaid and can vary both within and across markets. Additionally, the basis for hospital payment varies across payers as Medicare utilizes diagnosis related groups (DRGs), Medi-Cal switched from per diem to DRG-based payments in 2013, and in the commercial market, while the basis may vary, per diem is common in Los Angeles and San Francisco. Medi-Cal hospital payment rates are similar to the national Medicaid average.

For physician services, private insurers pay physicians higher rates than Medicare; for example, the US average payment for a primary care checkup is 118% of Medicare. Specialists command higher mark-ups over Medicare rates from private insurers; for example, a knee

replacement is 128% of Medicare and an emergency visit is 257% of Medicare. The presentation noted that commercial physician rates are lower than average in California; for example, 92% of Medicare in Los Angeles, and 108% of Medicare in San Francisco. For Medi-Cal, these rates are even lower as the national average in 2016 was 72% of Medicare while in California it is 52% of Medicare. In California, 77% of physicians would accept a new Medicare or privately insured patient, while only 54% would accept a new Medi-Cal patient.

e) Maryland All-Payer Model. This bill regulates the rates or amounts that health care entities receive as payment for health care services. Rate regulation is not a new concept and Maryland is a state that has established a global-payer system for hospital services.

Maryland's hospital rate regulation was created in 1971 and under this payment system, hospitals receive a rate for each of their services from the state, and all payers, including Medicare, Medicaid, private and uninsured pay off the same rate. It should be noted that under the Maryland model, Medicare and Medicaid pay higher than other states and private payers and uninsured pay less. Rates are updated annually on a prospective basis and differ for each hospital. Higher cost hospitals such as academic medical centers have higher rates and claim processing and benefit coverage are determined by each payer. It should be noted that Maryland has 47 acute general hospitals that are all non-profit; 54% of the population have employer coverage, 16% are on Medicaid, and 14% are on Medicare, and according to the Kaiser Family Foundation, has a 34% HMO penetration rate.

Maryland obtained a waiver (Section 1814(b) of the Social Security Act) for Medicare and Medicaid to pay 94% of the state regulated rates. The Health Services Cost Review Commission (HSCRC) oversees hospital rate regulation for all payers. HSCRC is an independent quasi-public commission, consisting of 7 volunteer Commissioners who are stakeholder representatives appointed by the Governor. The HSCRC has the authority to set the rates for inpatient and outpatient services but not physician services.

According to CMS, under this model, Maryland's hospitals have committed to achieving significant quality improvements, including reductions in Maryland hospitals' 30-day hospital readmissions rate and hospital acquired conditions rate. Maryland has agreed to limit all-payer per capita hospital growth, including inpatient and outpatient care, to 3.58 percent. Maryland has also agreed to limit annual Medicare per capita hospital cost growth to a rate lower than the national annual per capita growth rate per year for 2015-2018.

f) Rate setting under this bill. This bill defines base amount as the amount of payment for health care services as a percentage of Medicare rates that a health care entity may require from a purchaser as payment in full for health care services, in addition to applicable cost sharing. The base amount that the Commission will annually determine is a percentage of Medicare rates. This bill proposes the following:

i) Health Care Providers (such as physicians and hospitals). The percentage determined by the Commission cannot be lower than 100% of Medicare rates, and may exceed Medicare rates. The base amount must be a percentage of the rate that Medicare reimburses for the same or similar services in the general geographic region in which the services were rendered, unless those services are provided on a contractual basis to a health plan or health insurer licensed by the state. This bill specifies that in determining the base amount for

noncontracting physicians and other noncontracting health professionals, the Commission will use the average contracted amount in the general geographic regions for the three calendar years.

ii) Health Plan Contract or Health Insurance Policy. The base amount is a percentage of the capitated rate a health plan receives for Medicare Advantage for the county where an enrollee or insured resides, adjusted according to several factors including age, risk mix, and differences in cost sharing between the Medicare Advantage plan and the coverage offered by the health plan or health insurer. This bill includes factors that must be considered when setting the base amounts for health plans/health insurers, including financial solvency requirements, as specified.

A health plan or health insurer is permitted to negotiate contracted rates with contracting health providers that are not based on the Medicare rates as provided in i) above. Thus, the provisions in i) above apply to services provided where there is not a contract with a state-licensed health plan or insurer.

In determining the base amounts, the Commission will also consider the financial status of health care providers, including the compensation of physicians and other health professionals and whether the providers and plans/insurers are receiving a fair return on investment and avoidance of confiscatory results as well as changes in state or federal laws, reasonable increases in labor costs (including salaries and benefits), increases in capital investments, and changes in the delivery of care.

The Commission also has the authority to allow different percentages of Medicare rates to be used for different health care entities. Additionally, the Commission will have to establish a process for developing base amounts for health care services not currently reimbursed by Medicare or Medicare Advantage; for services infrequently reimbursed by Medicare/Medicare Advantage. The Commission shall also determine or not to include or alter Medicare rating factors, such as Medicare disproportionate share hospital rates, graduate medical education, readmission penalties, and other added rates as Medicare allows; adjust the rates to maintain the workforce necessary to deliver quality and equitable care, availability and accessibility of health care services (such as compliance with network adequacy, timely access and language access requirements); the impact of the base amounts in underserved areas, including rural and underserved areas; and may take into account other factors such as supplemental Medi-Cal rates, quality assurance fees, and other payment arrangements that exists for hospitals, clinics and other providers.

iii) Appeal Process. This bill also includes an appeal process to consider adjustments to the base amounts to be paid to health care entities. Decisions on appeals are to be rendered within six months of the appeal filing with complete documentation. The appeal must take into account several factors including the overall financial condition of the entity, fair return on investment, differences in costs among health care entities, factors such as natural disasters, outbreaks of epidemics or infectious diseases, labor costs, and changes in state or federal laws or in the delivery of care.

The Commission has authority to grant interim relief based on fairness and a decision on interim relief must be granted within one month of the filing of the interim relief appeal.

g) Massachusetts Global Cap. To contain growing health care costs, Massachusetts created a statewide global cap on public and private health care costs. The Massachusetts law specifies a target growth rate for overall medical spending based on the growth rate of the state's economy. This growth rate is a target for controlling growth of total health care expenditures across all payers.

Similarly, this bill requires the Commission to determine a global growth cap for total health expenditures, but not to exceed the annual growth of the gross state product. In fulfilling this function, the Commission has authority to obtain the information necessary to determine total health care expenditures in order to set the global growth cap.

h) DMHC Consumer Participation Program (CCP). This bill also establishes the Purchaser Participation Program to award reasonable advocacy and witness fees to a person or organization that represents the interests of purchasers and has made a substantial contribution on behalf of purchasers to the adoption of a regulation or to an order or decision that has a potential to impact a significant number of consumers. This program is similar to the CCP within DMHC. Existing law allows the DMHC Director to award reasonable advocacy and witness fees to any person or organization that demonstrates that the person or organization represents the interests of consumers and has made a substantial contribution on behalf of consumers to the adoption of any regulation or to an order or decision made by the DMHC Director if the order or decision has the potential to impact a significant number of enrollees. CCP caps the fees awarded at $350,000 each fiscal year. SB 97 (Committee on Budget and Fiscal Review), Chapter 52, Statutes of 2017, extended until January 1, 2024, the sunset date for the DMHC CPP. The statutory authority for the CPP was scheduled to sunset on January 1, 2018.

i) ERISA Plans. As specified above, under ERISA, states cannot impose requirements on self-insured plans. As specified above, about 6 million Californians obtain their coverage from self-insured plans. Under this bill, ERISA plans are permitted to access the rates set by the Commission for regulated health care entities.

j) Cost-shifting. According to an article posted in the National Institutes of Health (NIH) Internet Website entitled, "How much do hospitals cost shift: a review of evidence," hospital cost-shifting has long been part of the debate over health care policy. Under cost shifting, when government reimbursements under Medicare or Medicaid are insufficient to cover the costs of services, hospitals/facilities charge private insurance enough not only to cover the cost of their services but the shortfall created by government program reimbursements.

The NIH article examined literature on cost shifting since 1996 and the author found that "most of the analyses and commentary based on descriptive, industrywide hospital payment-to-cost margins by payer provide a false impression that cost shifting is a large and pervasive phenomenon. More careful theoretical and empirical examinations suggest that cost shifting can and has occurred, but usually at a relatively low rate. Margin changes also are strongly influenced by the evolution of hospital and health plan market structures and changes in underlying costs."

During testimony at a December 2017 informational hearing conducted by the Select Committee, a speaker from Maryland indicated that Maryland's all payer system limits cost

shifting since all payers pay their share, including uncompensated care and graduate medical education.

3) **SUPPORT**. The California Labor Federation (CLF), Health Access California (HAC), and SEIU California (SEIU) are the sponsors of this bill. HAC states that this bill helps rein in rising health care costs and protects consumer's pocketbooks by establishing an independent Commission that would set reasonable base amounts that hospitals, doctors, and health plans can collect from commercial payers. While preventing inflated and unjustified rates, providers are guaranteed rates higher than Medicare, which these providers generally accept as payment in full for much of their business, and can seek higher rates based on a variety of factors. SEIU California adds that this bill provides urgently needed relief to consumers, businesses, and governments, all of whom are currently straining under the weight of high health care costs. SEIU notes that although this bill would not set one rate across all payers in that it only applies to the commercial market, the Commission would be required to consider a provider's reliance on Medi-Cal and to make adjustments for lower Medi-Cal rates. Lastly, CLF indicates this bill is about fairness and will bring much-needed relief from the high price of health care to Californians and start to address the inequities in the health care system and that no Californian should have to go into debt to pay for basic health care. The sponsors conclude that this bill establishes a transparent process by which increases in health care costs can be kept reasonable.

   The League of California Cities supports this bill in concept but has concerns about the lack of city employer representatives on the Commission, and the process by which some members of the Commission are appointed and/or confirmed.

4) **CONCERNS**. The California Nurses Association has concerns with the concepts in this bill and among other concerns, indicates that this bill must be amended to include clear controls, such as caps on individual cost-sharing and rising healthcare premiums, providing the Commission both a mechanism and the authority to establish and enforce such limits. Additionally, language requiring consideration of profit of healthcare entities when establishing the base amount must be removed.

5) **OPPOSITION.** Numerous hospitals and providers are opposed to this bill. According to the California Hospital Association (CHA), among other arguments, under this bill hospitals stand to lose an estimated $18 billion annually in revenue. The payment reductions contained in this bill will lead to large cuts in hospital services, and force many hospitals, especially those in underserved areas, to close. Additionally, CHA estimates that the payment reductions in this bill will lead to an estimated 175,000 health care workers losing their jobs. CHA notes that this bill focuses exclusively on commercial insurance payments and ignores the significant shortfall in hospital payments from the Medicare and Medi-Cal programs, and the uncompensated care hospitals provide to patients.

   Kaiser Permanente (KP) believes that this bill undermines KP's unique integrated delivery system and argues that cost containment deserves more thoughtful discussion and that this bill does not address the underlying cost drivers and marketplace dynamics that are driving premium increases.

   The California Medical Association (CMA) and the California Academy of Family Physicians points out that this bill would lower commercial rates while doing nothing to improve access within Medi-Cal. CMA opines that this bill does nothing to addres the existing inefficiencies within the system that drive health care spending growth nor does it provide any incentives to

improve health care access and quality. This bill will force solo and small group practices into extinction as the only way to deal with administrative burdens and to use the appeals process successfully is to consolidate into large group practices. This could create an access crisis for patients living in rural and underserved areas in which there are no large group practices. CMA concludes that its biggest fear is that this bill will drive physicians out of the state and make it extremely difficult to recruit the next generation to come and practice in California.

6) RELATED LEGISLATION.

a) AB 2502 (Wood) requires the Secretary of the California Health and Human Services Agency (CHHSA) to establish, implement, and administer the California Health Care Payments Database. AB 2502 is pending in Assembly Health Committee.

b) AB 2517 (Wood and Arambula) establishes the Advisory Panel on Health Care Delivery Systems and Universal Coverage, within CHHSA, as an independent body, to develop a plan to achieve universal coverage and a unified publicly financed health care system. AB 2517 is pending in Assembly Health Committee.

c) SB 562 (Lara and Atkins) enacts the Healthy California program, which is required to provide comprehensive universal single-payer health care coverage system for all California residents. SB 562 is pending in Assembly Rules Committee.

7) AUTHOR'S AMENDMENTS.

a) Purpose of the Commission. To address concerns raised by the Committee that the Commission must consider the Medi-Cal rates in setting the base amount, the author proposes to clarify that the Commission will take into account the rates set by the Medi-Cal program in setting the amounts accepted as payment by health care providers, both for those health care providers who serve a disproportionate share of Medi-Cal beneficiaries and for those who provider highly specialized services.

b) Advisory Committee. The author proposes to increase the membership of the advisory committee to include a primary care physician; behavioral health provider; a representative of health professionals who are solo practitioners, as specified; and, a representative of Medicare access hospitals or other small or rural hospitals.

c) Clarifying amendments. The author proposes to clarify the definitions of adjusted amount and noncontracting provider; and clarify that the appeals process applies to all healthcare entities and not just providers.

d) ERISA. The author proposes to allow an employee welfare benefit plan to elect to pay the base and adjusted amounts set by the Commission for regulated health care providers.

e) Purchaser Participation Program (PPP). To address concerns raised by the Committee that the PPP should be narrowed, the author proposes to delete the ability of persons to participate in PPP and makes other conforming changes; to clarify that proceedings for purposes of the PPP to include: determination of the base amounts, appeals, overall cost, quality and equity goals, and other matters as determined by the Commission.

f) Base amounts. To address concerns raised by the Committee regarding additional factors that must be considered when determining the base amount, the author proposes to amend this bill to require the Commission, on an annual basis, to review Medi-Cal reimbursement, including both FFS and managed care rates, review information regarding adequacy of networks and timely access to care, and consider Medi-Cal reimbursement in determining base amounts.

The author also proposes to consider changes in Medicare rate or Medicare methodology in determining the base amount.

g) Technical and conforming changes. The author also proposes to fix drafting errors.

8) POLICY COMMENTS.

a) PPP. This bill establishes the PPP to award advocacy and witness fees to individuals or organizations that represent the interests of consumers, as specified. Consistent with the DMHC's CPP which imposes a limitation on the amount of fees awarded, and includes a sunset date, the Committee may wish to amend this bill to apply the same limitations to the PPP.

b) Medi-Cal exception. As drafted, this bill excludes Medicare and Medi-Cal programs. As stated above, about 14 million beneficiaries or one-third of California's population are enrolled in Medi-Cal. Excluding Medi-Cal from this bill could have serious consequences, especially to providers who disproportionately serve high Medi-Cal beneficiaries. Although under this bill, the Commission may take into account the reliance of a healthcare provider on Medi-Cal reimbursement and pursuant to amendments being proposed by the author to require the Commission to review Medi-Cal reimbursement, an additional accommodation for providers who have a disproportionate share of Medi-Cal beneficiaries may be appropriate. For example, the Committee may wish to consider allowing the Commission to provide incentives to providers to accept Medi-Cal patients. Additionally, providers who have a high percentage of Medi-Cal enrollments should be allowed to have a higher base amount to ensure access for Medi-Cal beneficiaries.

c) Prescription Drugs. According to a July 2017 Commonwealth Fund report, historic increases in prescription drug spending and prices are contributing to unsustainable health care costs in the United States. A 2016 CHCF issue brief points out that pharmaceutical prices in the U.S. are among the highest worldwide. For example, spending on just 10 medications alone is estimated to cost the federal government (Medicare, Medicaid, and health exchange subsidies) nearly $50 billion over a decade, and these drugs represent a small subset of the more than 5,400 medications in the drug pipeline. As the author and sponsors point out the high cost of health care is becoming unaffordable for many Californians. Although this bill gives the Commission the authority to determine methods for state government to reduce the cost of prescription drugs and medical devices paid for by private purchasers in the commercial market, the Committee may wish broaden these duties in recognition of the overall impact of escalating drug costs. For example, the Commission's purpose or duties could include gathering information about drug prices, reviewing the impact of prescription drugs on rates, determining whether the state should pursue value-based prescription drug purchasing for state programs, and evaluate whether there is a mechanism for the state to set rates for high cost drugs.

d) Funding. As drafted, this bill would be funded by the existing Managed Care Fund and the Insurance Fund which are supported by assessments/fees from health plans and health insurers. The Committee may wish to explore the viability of using GF to support the Commission.

REGISTERED SUPPORT / OPPOSITION:

Support

California Labor Federation (cosponsor)
Health Access California (cosponsor)
SEIU California (cosponsor)
UNITE HERE International Union (cosponsor)
Americans for Democratic Action Southern California
Business Alliance for a Healthy California
CA Conference Board of the Amalgamated Transit Union
CA Conference of Machinists
California Immigrant Policy Center
California Pan-Ethnic Health Network
California School Employees Association
California State Council of the Service Employees International Union
California Teachers Association
California Teamsters
Communications Workers of America District 9
Congress of California Seniors
Consumers Union
Engineers & Scientists of CA, IFPTE Local 20, AFL-CIO
International Longshore and Warehouse Union
JGlynn & Co
Jockeys' Guild
Professional and Technical Engineers, IFPTE Local 21, AFL-CIO
San Francisco AIDS Foundation
Service Employees International Union Local 1000
UDW/AFSME Local 3930
United Food and Commercial Workers Western States Council
University Professional and Technical Employees-CWA Local 9119
Utility Workers Union of America
Western Center on Law and Poverty

Opposition

Adventist Health - Feather River
Adventist Health – Lodi Memorial
Adventist Health - Simi Valley
Adventist Health - White Memorial
Adventist Health Hanford
Adventist Health Howard Memorial
Adventist Health Sonora
Adventist Health St. Helena
Adventist Health St. Helena Hospital Clear Lake
Adventist Health Ukiah Valley
Alliance of Catholic Health Care
American Academy of Pediatrics, California
American Association of Nurse Anesthetists
American College of Obstetricians and Gynecologists District IX
American College of Physicians – California Chapter
American College of Surgeons
America's Physician Groups
Association of California Healthcare Districts
Association of Northern California Oncologists
Barton Health - Barton Memorial Hospital
Brea Chamber of Commerce
Building Owners and Managers Association
California Academy of Eye Physicians & Surgeons
California Academy of Family Physicians
California Ambulance Association
California Association of Health Facilities
California Association of Health Plans
California Association of Nurse Anesthetists
California Building Industry Association
California Business Properties Association
California Chamber of Commerce
California Chapter of the American College of Cardiology
California Chapter of the American College of Emergency Physicians
California Chapters of the American College of Physicians
California Children's Hospital Association
California Dental Association
California Dental Hygienists Association
California Hospital Association
California Medical Association
California Neurology Society
California Optometric Association
California Podiatric Medical Association

California Psychiatric Association
California Radiological Society
California Retailers Association
California Rheumatology Alliance
California Society of Allergy, Asthma and Immunology
California Society of Dermatology & Dermatologic Surgery
California Society of Pathologists
California Society of Plastic Surgeons
California Society for Respiratory Care
Camarillo Chamber of Commerce
CAPA
Carlsbad Chamber of Commerce
Carson Chamber of Commerce
Cedars-Sinai Medical Center
Centinela Hospital Medical Center
Cerritos Chamber of Commerce
Chinese Hospital
City of Hope
Coast Plaza Hospital
Community Hospital of Huntington Park
Community Medical Centers
Community Memorial Health System, Ventura
Corona Regional Medical Center
Dignity Health - Sacramento Area
Dignity Health Dominican Hospital
Dignity Health French Hospital Medical Center
Dignity Health Saint Francis Memorial Hospital
District Hospital Leadership Forum
Doctors Hospital of Manteca
Doctors on Duty Urgent Care Clinics
East Bay Leadership Council
East Los Angeles Doctors Hospital
Eastern Plumas Health Care District
El Camino Hospital
El Centro Regional Medical Center
Fairchild Medical Center
Folsom Chamber of Commerce
Fresno Chamber of Commerce
Gateway Chambers Alliance
Greater Bakersfield Chamber of Commerce
Greater Coachella Valley Chamber of Commerce
Greater Conejo Valley Chamber of Commerce
Greater West Covina Business Association
Hazel Hawkins Memorial Hospital
HealthSouth Bakersfield Rehabilitation Hospital
Henry Mayo Newhall Hospital
Hospital Corporation of America
International Council of Shopping Centers
Irwindale Chamber of Commerce
John C. Fremont Healthcare District
John Muir Health
Kaiser Permanente
Kaweah Delta Health Care District
Keck Medicine of University of Southern California
Kern Medical
Kern Valley Healthcare District
Kindred Healthcare - San Francisco Bay
Kindred Hospital - Baldwin Park
Kindred Hospital - Brea
Kindred Hospital - Los Angeles
Kindred Hospital - San Diego
Kindred Hospital - San Gabriel Valley
Kindred Hospital - Santa Ana
Kindred Hospital - La Mirada
Kindred Hospitals - Rancho Cucamonga
Kindred Hospitals - Riverside
Kindred Hospitals of Southern California
Loma Linda University Health
Loma Linda University Medical Center - Murrieta
Lompoc Valley Medical Center
Los Angeles Area Chamber of Commerce
Los Robles Hospital and Medical Center
Mad River Community Hospital
Madera Community Hospital
Marshall Medical Center
Mayers Memorial Hospital District
Memorial Hospital of Gardena
MemorialCare
Mendocino Coast District Hospital
Methodist Hospital of Southern California
Mission Community Hospital
Modoc Medical Center
Molina Healthcare
Monterey Peninsula Chamber of Commerce
Mountain Communities Healthcare District (Trinity Hospital)
Mountain View Chamber of Commerce
Mountains Community Hospital
Murrieta/Wildomar Chamber of Commerce
National Association of Chain Drug Stores
National Association of Industrial and Office Properties of California
National Federation of Independent Business
North Orange County Chamber of Commerce
NorthBay Healthcare
Northern Inyo Hospital
Orange County Business Council
Osteopathic Physicians & Surgeons of California
Oxnard Chamber of Commerce
Palmdale Regional Medical Center

Palo Verde Hospital
Paradise Valley Hospital
Petaluma Area Chamber of Commerce
Physical Medicine and Rehabilitation
Physicians for Healthy Hospitals
PIH Health
Plumas District Hospital
Prime Healthcare
Providence Little Company of Mary Medical Center San Pedro
Providence Little Company of Mary Medical Center Torrance
Providence Saint John's Health Center
Providence Saint Joseph Medical Center
Queen of the Valley Medical Center
Rady Children's Hospital San Diego
Rancho Cordova Chamber of Commerce
Redlands Community Hospital
Redondo Beach Chamber of Commerce
Salinas Valley Memorial Healthcare System
San Diego Regional Chamber of Commerce
San Gabriel Valley Economic Partnership
San Joaquin General Hospital
Santa Maria Valley Chamber of Commerce
San Mateo County Economic Development Association
Scripps Health
Seneca Healthcare District
Sharp Healthcare
Shasta Regional Medical Center
Sierra View Medical Center
Silicon Valley Leadership Group
Sonoma Valley Hospital
South Bay Association of Chambers of Commerce
Southern Humboldt Community Healthcare District
Southwest California Legislative Council
Southwest Healthcare System
Southwest Healthcare System – Inland Valley
Southwest Healthcare System – Rancho Springs Medical Center
St. Joseph Health (Redwood Memorial and St. Joseph Hospital, Eureka)
St. Joseph Health (Santa Rosa Memorial and Petaluma Valley)
St. Joseph Health (Humboldt County and Sonoma County)
St. Joseph Hospital of Orange
St. Joseph's Behavioral Health Center
St. Mary Medical Center (Apple Valley)
Stanford Health Care
Stanford Hospital
STAT MED Urgent Care
Sutter Health - Mills-Peninsula Medical Center
Sutter Health - Sutter Lakeside Hospital
Sutter Health California Pacific Medical Center
Sutter Health Eden Medical Center
Sutter Health Novato Community Hospital
Sutter Health Sutter Delta Medical Center
Sutter Health Sutter Maternity & Surgery Center of Santa Cruz
Sutter Health Sutter Santa Rosa Regional Hospital
Sutter Health Tracy Community Hospital
Tahoe Forest Health System
Temecula Valley Hospital
Tenet Healthcare
Torrance Area Chamber of Commerce
Torrance Memorial Medical Center
Tulare Chamber of Commerce
United Chamber Advocacy Network
United Hospital Association
Universal Health Services
Valley Children's Healthcare
Valley Industry and Commerce Association
VIBRA Hospital of Sacramento
VICA
VISTA Chamber of Commerce
VSP Vision Care
Watsonville Community Hospital
Western Manufactured Housing Communities
Yubadocs Urgent Care Center

Analysis Prepared by: Rosielyn Pulmano / HEALTH / (916) 319-2097

April 20, 2018

The Honorable Ash Kalra
California State Assembly
State Capitol Room 5160
Sacramento, CA 95814

SUBJECT: OPPOSE: AB 3087, THE CALIFORNIA HEALTH CARE COST, QUALITY, AND EQUITY COMMISSION

Dear Assemblymember Kalra:

I write on behalf of the East Bay Leadership Council (EBLC), in opposition to AB 3087 as amended April 9, 2018, which would reduce access to care and add a counterproductive layer of additional bureaucracy. There is no question that health care costs are rising and making it more difficult for employers and their employees to afford quality accessible care. AB 3087 would likely have the short-term result of less access to health care and a long-term result of accelerating cost increases.

Price controls ignore the underlying reason for the cost of services and products. Most economists believe price controls keep prices artificially low, suppressing supply and in turn resulting in unmet demand. In the case of health care, the lack of supply means fewer health care providers. Without an adequate supply of health care providers, consumers may pay less but not have access to the care they need.

AB 3087 also establishes an appointed commission to impose price controls on health care providers and insurers and determine the amount of an individual's copays and deductibles. While the bill contains language for a health care entity to appeal the rates, the process still leaves decisions as to what is "fair" to an appointed board, an administrative judge and judicial review. Without adequate reimbursement levels, price controls will drive providers and insurers out of the market.

Further, this bill empowers the commission to decide the level of copays, deductibles, coinsurance and any other share of cost for services. Employers are active purchasers and negotiate with health plans on prices, networks, and quality measures. The ultimate price plays a key role in other facets of a health plan such as the number of doctors offered to patients or cost-sharing. Under AB 3087 those issues are delegated to the new Commission.

Hospitals have already identified a loss of $18 billion if AB 3087 is enacted. For some communities, this could mean their hospital will close its doors. Simply capping the rates will not make the costs in the healthcare system disappear, but instead will limit choices, access, and increase costs for employers and their employees. For these reasons, we oppose AB 3087.

Sincerely,

Kristin Connelly
President & CEO

Cc: Honorable Jim Wood, Chair, Committee on Health, California State Assembly

KAISER PERMANENTE®

April 10, 2018

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

RE: AB 3087 (Kalra) – *OPPOSE*

Dear Dr. Wood:

Kaiser Permanente opposes AB 3087, which will create a centralized, politicized government commission to set health care rates in California. The bill produces the same fundamentally disruptive effect as SB 562, without curing the underlying market instability that complicates coverage accessibility and affordability for Californians. California's health care marketplace is a shining example for other public and private payers across the country exploring payment reform and accountable care models, where high quality and positive outcomes are shared goals. We are learning important lessons about how to create health care value for consumers. Those models have shown promise and they should be encouraged and replicated, not punished with price-setting schemes. We should collectively pursue opportunities to build off this success rather than centrally planning an entirely new system.

Cost containment deserves more thoughtful discussion.

Kaiser Permanente agrees with the goal of AB 3087, to reduce health care costs in California. We strive each day to improve affordability for our members. But AB 3087 takes a radical approach that was developed without any input whatsoever from those who actually finance and deliver health care. Until real payment and delivery system reforms are addressed, these kinds of "band-aid" proposals may grab headlines but will destabilize and disrupt the state's health care market. Specifically, AB 3087 does not address the underlying cost drivers and marketplace dynamics that are driving premium increases — including prescription drug prices, unmanaged chronic conditions, misaligned financial incentives, an aging population, healthcare workforce demands, benefit mandates, new rules and regulations that drive up plan and provider administrative costs, and seismic retrofit requirements.

AB 3087 undermines Kaiser Permanente's unique integrated delivery system.

As the state's largest private employer, Kaiser Permanente's 160,000 employees and physicians collaborate in the care and coverage of 8.5 million Californians. AB 3087 would fundamentally destabilize our world-renowned model and create significant upheaval for the individuals, businesses and public employers who purchase coverage from us, as well as for our employees, vendors and contractors.

Our integrated model, made possible through a carefully nurtured, unique partnership among three entities – our medical groups, our hospitals and our health plan – would be fundamentally destabilized by the bill's rigid price-fixing system. An arbitrary, one-size-fits-all premium would cripple our ability to finance our delivery system and provide the level of care and coverage and access our members deserve and expect.

Central planning is not market stabilization.

By putting health care finance in the hands of a government bureaucracy, AB 3087 will simply starve the system and produce myriad negative consequences. Empowering a central government authority to determine premium costs and provider rates will lead to restrictions on benefits, coverage levels, and access. In reality, the authority

Government Relations
1215 K Street, Suite 2030
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enjoys only a handful of options to actually control costs: raise premiums, force cuts in benefits, seek new taxes or create barriers to medical treatment – potentially even rationing care. Any of these options only undermine access and affordability for Californians.

AB 3087 ties Kaiser Permanente's hands in serving its members and communities.

Under AB 3087, the commission would determine whether resources would be available for capital expenditures. This would require higher base rates – an unlikely scenario with the politicized nature of the commission and the pressure to keep costs down. The process in the bill is unclear, but it would likely be a bureaucratic nightmare to secure adequate resources to invest in capital needs, which will jeopardize our ability to meet the health care system's vast infrastructure demands, such as building new hospitals and investing in equipment, technology and electronic medical records. These require significant capital expenditures, as well as an understanding of and commitment to the needs of a local community and years of planning. When rates are not adequate and the money runs out, where will the commission turn to finance these critical projects?

AB 3087 ignores out-of-control prescription drug prices.

While Kaiser Permanente does not endorse rate setting of any kind, the bill's complete lack of focus on pharmaceuticals is astounding. Drug spending accounts for nearly 20% of health care spending – how is it possible to contain costs in the health care system while completely ignoring one of the largest and most unfettered contributors to increasing costs? The absence of any effort to hold pharmaceutical companies accountable for their skyrocketing prices only reveals the lack of any sincere interest in solving real problems while punishing good actors in the system.

AB 3087 siphons precious health care dollars out of care – and to the bill's supporters.

Stunningly, the bill creates an income stream for so-called "purchaser participation," where advocates would be compensated to represent consumers before the commission. The funding source would be fees from the entities regulated by the bill – health plans and health care providers. This is the Proposition 103 intervenor model where "consumer advocates" make millions off the process. This provision in AB 3087 will divert precious health care resources into the pockets of supporters of the bill instead of into actual patient care.

The Affordable Care Act is working in California – but there is more work to do.

It is remarkable that this bill is being put forward, while the Legislature is not entertaining a state-level proposal to require individuals to buy coverage to replace the effectively repealed federal mandate. The absence of a robust individual mandate will cause health care premiums to rise in California by at least 35% in the next three years, on top of current trend. We need to stabilize our health care system so that people can count on it in the future, not create more uncertainty with proposals like AB 3087.

AB 3087 will cause upheaval at a time when we need stabilizing responses to disruptive federal changes. For the above reasons we urge a "no" vote on this measure.

Sincerely,

Teresa Stark

Teresa Stark
Director, State Government Relations

cc: Assemblyman Ash Kalra
Assembly Health Committee Members
Kristene Mapile, Assembly Health Committee Consultant
Peterson Anderson, Assembly Republican Caucus

ALAMEDA-CONTRA COSTA MEDICAL ASSOCIATION

6230 CLAREMONT AVE. • P.O. BOX 22895 • OAKLAND, CA 94609-5895 • TEL 510/654-5383 • FAX 510/654-8959

April 17, 2018

The Honorable Karen Mitchoff
President, Contra Costa County Board of Supervisors
2151 Salvio Street, Suite R
Concord, CA 94520

RE: **East Bay Physicians Urge Opposition to AB 3087**

Dear President Mitchoff and Honorable Members of the Board:

On behalf of the 4,200 members of the Alameda-Contra Costa Medical Association, we are writing to ask the Contra Costa County Board of Supervisors to join us in opposing AB 3087 (Kalra), which would establish an unelected commission of nine individuals to set physician and hospital rates for commercial health care services in California. We are especially concerned about the consequences for patients from the diminished access to care that would result if AB 3087 becomes law. We urge you to join us in opposing this flawed legislation. Please consider the following points:

AB 3087 will harm access to care for California patients. By only seeking to reduce commercial rates without also increasing Medicare and Medi-Cal rates, AB 3087 will jeopardize the historic gains California has made over the past several years to expand health coverage and access as a result of the Affordable Care Act. The bill does nothing to address chronically low reimbursement in Medicare and Medi-Cal, which for decades have been the major barrier to patients covered by those programs accessing services. California's Medi-Cal provider rates are among the lowest in the nation and do not cover the actual costs of services, and AB 3087 will further limit the volume of Medicare and Medi-Cal patients that physicians can see without risking their own financial viability. Medicare and Medi-Cal patients already have a challenging time accessing some medical services in our community, and AB 3087 would exacerbate this problem for seniors, the disabled, individuals of limited means, and others covered by Medicare and Medi-Cal.

AB 3087 will exacerbate California's physician shortage. California is currently suffering from a physician shortage. California ranks 32nd in the number of primary care residents and fellows per 100,000 population, six of nine California regions are facing a primary care provider shortage, and 23 of California's 58 counties fall below the minimum required primary care physician-to-population ratio. California is among the highest tax states with a very high cost of living, and the average medical student is graduating with $200,000 in debt. AB 3087 would drive physicians out of the state and make recruiting new physicians extremely difficult, thereby depleting the physician workforce. Physicians nearing retirement would opt for early retirement, and young physicians would opt to practice elsewhere. Hospitals and medical groups would face great difficulty recruiting physicians to practice here compared to other states. Again, it is

patients who would ultimately suffer if AB 3087 becomes law and exacerbates California's physician shortage.

AB 3087 is an attack on the medical profession. The bill establishes an unelected Commission of nine individuals to set physician rates, which will be funded in part using physician licensing fees, yet physicians are expressly prohibited from serving on the Commission. While there is technically an appeals process established in AB 3087 to challenge the rates, the responsibility for making appeal decisions is vested with the same Commission who set the original base rates.

AB 3087 flies in the face of the expert recommendations from the recently commissioned UCSF report "A Path to Universal Coverage and Unified Health Care Financing in California", which included 1) increasing Med-Cal reimbursement rates to increase access; and 2) developing a comprehensive strategy to ensure a robust physician workforce. AB 3087 would be a major step backwards in advancing these recommendations.

California has made great progress increasing coverage and access to care. We have embraced the Medi-Cal expansion, started Covered California, and passed the Proposition 56 tobacco tax to increase reimbursement rates and improve access to care in the Medi-Cal program. AB 3087 would destabilize the commercial health insurance market and would be a step back in California's efforts to expand access to care. For these reasons, the ACCMA asks for you to oppose this misguided and dangerous legislation.

Sincerely,

Thomas Sugarman, MD
ACCMA President

Cc: Janus Norman, Senior Vice President, CMA Government Relations

Contra Costa County Board of Supervisors

Subcommittee Report

LEGISLATION COMMITTEE **8.**

Meeting Date: 05/14/2018
Subject: SB 910 (Hernandez): Short-term Limited Duration Health Insurance
Submitted For: LEGISLATION COMMITTEE,
Department: County Administrator
Referral No.: 2018-19
Referral Name: SB 910 (Hernandez)
Presenter: Patricia Tanquary **Contact:** L. DeLaney, 925-335-1097

Referral History:

SB 910 (Hernandez): Short-term Limited Duration Health Insurance, is a bill that would prohibit a health insurer from issuing, selling, renewing, or offering a short-term limited duration health insurance policy for health care coverage in this state. The bill was referred to the Legislation Committee by the Chief Executive Officer of the Contra Costa Health Plan with a recommendation to "Support."

Author:	Ed Hernandez (D-022)
Title:	Short-term Limited Duration Health Insurance
Fiscal Committee:	yes
Urgency Clause:	no
Introduced:	01/18/2018
Last Amend:	03/05/2018
Disposition:	Pending
Committee:	Senate Appropriations Committee
Hearing:	05/14/2018 10:00 am, John L. Burton Hearing Room (4203)

Referral Update:

The text of SB 910 is available here:
http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180SB910

The bill analysis for the Senate Health Committee is as follows:

2017 CA S 910: Bill Analysis - 03/12/2018 - Senate Health Committee, Hearing Date 03/14/2018

BILL NO: SB 910 AUTHOR: Hernandez VERSION: March 5, 2018 HEARING DATE: March 14, 2018 CONSULTANT: Teri Boughton SUBJECT: Short-term limited duration health insurance

SUMMARY:

Prohibits a health insurer from issuing, amending, selling, renewing, or offering a policy of short-term limited duration health insurance in California commencing January 1, 2019.

Existing law:

1) Exempts, under federal law, short-term limited duration policies from the definition of individual health insurance. [42 USC Section 300gg-91 (b)(5), 45 CFR Section 144.103]

2) Establishes the Department of Managed Health Care (DMHC) to regulate health plans and the California Department of Insurance (CDI) to regulate health insurance. [HSC Section 1340, et. seq., and IC Section 106, et. seq.]

3) Defines, under state law relating to conversion coverage requirements, short-term limited duration health insurance to mean individual health insurance coverage that is offered by a licensed insurance company, intended to be used as transitional or interim coverage to remain in effect for not more than 185 days, that cannot be renewed or otherwise continued for more than one additional period of not more than 185 days, and that is not intended or marketed as health insurance coverage, a health plan, or a health maintenance organization subject to guaranteed issuance or guaranteed renewal pursuant to relevant state law. [IC Section 12671 (e)(8)]

4) Makes inoperative on January 1, 2014, a requirement on a health insurer to entitle an employee or member whose coverage under a group policy has been terminated to a converted policy issued by the insurer. [IC Section 12672]

5) Requires all individual health benefit plans, except short-term limited duration insurance, to be renewable with respect to all eligible individuals or dependents at the option of the individual, with exceptions such as for fraud and abuse or if the carrier ceases to provide coverage in the state, among other circumstances. [HSC Section 1367.29 and IC Section 10273.6]

6) Exempts short-term limited duration health insurance from existing requirements on health plans that cover mental health services, and on health insurance rate increase notifications, requirements on health insurance policies that include professional mental health services, orthotic and prosthetic devices and services, mammography, maternity services, and reproductive and sexual health care services. [HSC Section 1367.29 and Section 1368.016, IC Section 10113.9, Section 10123.7, Section 10123.81, Section 10123.865, Section 10123.866, Section 10123.198, Section 10123.199, and Section 10123.202]

This bill:

1) Prohibits a health insurer, commencing January 1, 2019, from issuing, amending, selling, renewing, or offering a policy of short-term limited duration health insurance in California.

2) Defines "short-term limited duration health insurance" as health insurance coverage provided pursuant to a health insurance policy that has an expiration date that is less than 12 months after the original effective date of the coverage, including renewals.

3) Deletes all exemptions in existing law for short-term limited duration health insurance and revises the definition that is in an inoperative provision of law so that it is consistent with 2) above.

FISCAL EFFECT:

This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) Author's statement. According to the author, short-term limited duration health insurance offers very limited value in a state like California that has embraced the Affordable Care Act (ACA) and been very successful at expanding comprehensive coverage such that only 6.8% of the state's population is uninsured. Expanded access to insurance coverage is important but coverage also must be comprehensive, affordable and accessible to all. California has been enacting policies to rid the individual and small group markets of junk insurance even before the ACA. With the ACA's reforms that ensure guaranteed issue of products, prevent underwriting, and require inclusion of essential health benefits, there is no reason to allow these noncompliant products to remain in the market. These products only serve to confuse and mislead Californians into a false security that their health care needs will be covered. These products are not made available to everyone, and in addition to confusing consumers, they are destabilizing to the ACA market, resulting in increased premiums for ACA products. The Urban Institute has released an issue brief stating that average premiums in the ACA-compliant individual insurance market would increase approximately 18% in the states that do not prohibit or limit expanded short-term limited duration plans. This increase includes the impact of the elimination of the individual mandate penalties. For California, the brief indicates a 17.8% premium increase for 2019.

2) Short-term limited duration coverage. According to a December 2017 brief by the Georgetown University Health Policy Institute Center on Health Insurance Reforms, short-term limited duration insurance is health insurance that, by definition, covers someone for less than 12 months and is not renewable. It was designed to fill temporary gaps in coverage. These policies do not have to meet ACA consumer protection requirements and they are generally issued to consumers who can pass medical underwriting. These policies provide minimal financial protection for insureds who become sick or injured. According to one analysis described in the brief, these policies regularly excluded coverage for preexisting conditions, did not cover mental health and substance use services, maternity care, or prescription drugs and included out-of-pocket maximums ranging from $7,000 to $20,000 for only three months of coverage.

3) Federal regulations. Under the ACA, group and individual health insurance cannot include preexisting condition exclusions, discriminate based on health status, have lifetime and annual limits, and they are required to cover preventive health services, dependent coverage to age 26, offer guaranteed issue and renewability of coverage, and cover essential health benefits among other requirements. Under the Obama Administration, federal regulations were adopted to prohibit insurers from offering short-term limited duration policies that lasted longer than three months and required each policy to include a prominent notice that it is not minimum essential

coverage, which is coverage that individuals must have to meet ACA requirements and not be subject to a penalty. Effective in 2019, the financial penalty for not having insurance was reduced to zero by the federal Tax Cut and Jobs Act of 2017. The Obama regulations took effect January 1, 2017. However, the federal departments of Health and Human Services, Labor and Treasury indicated they would not enforce the requirement that short-term coverage be less than three months for products sold before April 1, 2017, as long as the coverage ends on or before December 31, 2017. The Trump Administration issued a proposed rule on February 20, 2018 to expand the maximum coverage duration to up to 364 days and change the notice requirement to reflect that the individual mandate penalty is no longer in effect in 2019. The notice also warns that coverage lapsing midyear may create a coverage gap until the next open enrollment period is available. Under both sets of regulations, the departments estimate that approximately 100,000 to 200,000 additional individuals would shift from the individual market to short-term limited duration insurance in 2019. The departments estimate the majority of those who switch would be young and healthy and 90% would be unsubsidized. Once finalized, the Trump regulations will take effect 60 days upon publication.

4) Short-term limited duration health plans in CA. According to DMHC, the Knox-Keene Act (California law that regulates health plans) is silent on the matter of short-term limited duration health insurance but these policies do not comply with many minimum standards required under the Knox-Keene Act. However, these policies do appear to be subject to some type of regulation under the CDI. CDI indicates that gaps in the intersection of federal and California law make some of these policies arguably permissible in California. CDI indicates that many existing state insurance mandates apply to these policies. In a December 8, 2017 Los Angeles Times article, Insurance Commissioner Dave Jones indicates that CDI estimates there are only a few thousand active short-term policies across the state. In the same article, a representative of eHealth.com, a private online health insurance marketplace, indicates that there are not many carriers willing to offer state residents short-term limited duration options.

5) Related legislation. SB 1287 (Hernandez) pending in the Senate Rules Committee, states legislative intent to enact legislation that would regulate multiple employer welfare arrangements and other types of association health plans to the extent permitted under federal law, including ensuring that those plans meet minimum financial solvency and reporting requirements.

6) Prior legislation. AB 1180 (Pan, Chapter 441, Statutes of 2013) makes inoperative several provisions in existing law that implement the health insurance laws of the federal Health Insurance Portability and Accountability Act of 1996 and additional provisions that provide former employees rights to convert their group health insurance coverage to individual market coverage without medical underwriting, because of the ACA. Establishes notification requirements informing individuals affected by AB 1180 of health insurance available in 2014 under the ACA.

7) Support. Health Access California writes that short-term insurance shortchanges consumers in two ways. First, consumers are lured to these products by cheaper premiums and secondly, short-term insurance plans lack important ACA protections. Without this bill, the pending federal rule will relegate California's individual insurance market back to the pre-ACA days when consumers were left without care because of loopholes that left those who need maternity care, chemotherapy, or prescription drugs behind. Proponents indicate that this bill would maintain the stability of California's individual market by ensuring health coverage sold in California provides comprehensive benefits and consumer protections. Short-term insurance is bad for consumers

because it lacks basic protections and essential health benefits that cover prescription drugs, maternity care, mental health, and other vital services. Kaiser Permanente supports this bill because short-term plans may cause healthier people to leave comprehensive coverage and choose an alternative plan in the individual or group market, which in turn will lead to market segmentation that will result in higher premiums. Kaiser writes that short-term insurance is detrimental to consumers and will destabilize the individual market in California, leading to premium increases.

8) Opposition. Anthem Blue Cross opposes a strict prohibition on short-term limited duration health insurance and supports extending the permitted duration of short-term limited duration health insurance plans to 364 days per the proposed federal rule. Anthem Blue Cross believes, when used appropriately, these policies do serve an important purpose as an affordable source of coverage for individuals who are between plans and that 364 days of coverage is necessary in some cases, such as when an individual misses the deadline for open enrollment, or is between jobs and cannot afford COBRA (COBRA is the Consolidated Omnibus Budget Reconciliation Act, which requires a health plan to offer an outgoing employee continued coverage but without the employer's premium subsidy). The California Association of Health Underwriters (CAHU) believes this bill removes a critical tool for coverage and leaves affected individuals with no option other than to utilize costly emergency services should a need arise. CAHU requests amendments making these plans available to those who are otherwise legally prohibited from purchasing comprehensive coverage and limited until the next open enrollment.

SUPPORT AND OPPOSITION:

Support: Health Access California (sponsor)

American Cancer Society Cancer Action Network

APLA Health

Asian Law Alliance

Blue Shield of California

California Health Professional Student Alliance

California Immigrant Policy Center

California Labor Federation

California Physicians Alliance

California Rural Legal Assistance Foundation

ChapCare

Children's Defense Fund California

Consumers Union

Disability Rights California

Equality California

Kaiser Permanente

Latino Coalition for a Healthy California

Maternal and Child Health Access

National Health Law Program

San Francisco AIDS Foundation

Western Center on Law & Poverty

Oppose: Anthem Blue Cross

California Association of Health Underwriters

Recommendation(s)/Next Step(s):

CONSIDER recommending to the Board of Supervisors a position of "Support" for SB 910 (Hernandez), and sending to the Board of Supervisors for their consent.

Attachments

No file(s) attached.

Contra Costa County Board of Supervisors

Subcommittee Report

LEGISLATION COMMITTEE **9.**

Meeting Date: 05/14/2018
Subject: SB 974 (Lara): Medi-Cal: immigration status: adults
Submitted For: LEGISLATION COMMITTEE,
Department: County Administrator
Referral No.: 2018-18
Referral Name: SB 974 (Lara)
Presenter: Patricia Tanquary **Contact:** L. DeLaney, 925-335-1097

Referral History:

SB 974 (Lara) was referred to the Legislation Committee by Patricia Tanquary, the CEO of the Contra Costa Health Plan with a recommendation of "Support."

Author:	Ricardo Lara (D-033)
Coauthor	Hertzberg (D) , Leyva (D) , Pan (D) , Mitchell (D) , Hueso (D) , Bradford (D) , Skinner (D) , Monning (D) , Hernandez (D) , Galgiani (D) , de Leon (D) , Beall (D) , Wiener (D)
Title:	Medi-Cal: Immigration Status: Adults
Fiscal Committee:	yes
Urgency Clause:	no
Introduced:	02/01/2018
Disposition:	Pending
Location:	Senate Appropriations Committee
Summary:	Extends eligibility for full-scope Medi-Cal benefits to individuals of all ages who are otherwise eligible for those benefits but for their immigration status.

Referral Update:

The text of the bill can be found here:
http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180SB974

Attachment A is the Senate Committee on Health bill analysis. CSAC's position on the bill is pending.

This bill:

1) Makes undocumented adults age 19 and older who meet all of the eligibility requirements for

full-scope Medi-Cal benefits, except for their immigration status, eligible for full-scope Medi-Cal benefits.

2) Requires undocumented individuals already enrolled in limited scope Medi-Cal to be enrolled pursuant to an eligibility and enrollment plan, which includes outreach strategies developed by DHCS in consultation with interested stakeholders, including but not limited to counties, health plans, consumer advocates and the Legislature.

3) Requires undocumented individuals to enroll into Medi-Cal managed care health plans, and to pay copayments and premium contributions to the extent required of otherwise eligible Medi-Cal recipients who are similarly situated.

4) Requires DHCS to maximize federal financial participation in implementing these requirements to the extent allowable.

Recommendation(s)/Next Step(s):

CONSIDER recommending to the Board of Supervisors a position of "Support" on SB 974 (Lara), a bill that extends full-scope Medi-Cal benefits to undocumented adults age 19 and above who are otherwise eligible for those benefits but for their immigration status and send the bill to the Board for their consent.

Fiscal Impact (if any):

This bill has not been analyzed by a fiscal committee of the state legislature.

Attachments

Attachment A: Bill Analysis

SENATE COMMITTEE ON HEALTH
Senator Ed Hernandez, O.D., Chair

BILL NO: SB 974
AUTHOR: Lara
VERSION: February 1, 2018
HEARING DATE: April 4, 2017
CONSULTANT: Scott Bain

SUBJECT: Medi-Cal: immigration status: adults

SUMMARY: Extends eligibility for full-scope Medi-Cal benefits to undocumented adults age 19 and above who are otherwise eligible for those benefits but for their immigration status.

Existing federal law: Prohibits undocumented individuals from being eligible for any state or local public benefits (including Medicaid), except for assistance for health care items and services that are necessary for the treatment of an emergency medical condition, public health assistance for immunizations, and for testing and treatment of symptoms of communicable disease. [8 U.S. Code §1621]

Existing state law:

1) Establishes the Medi-Cal program, administered by the Department of Health Care Services (DHCS), under which low income individuals are eligible for medical coverage. [WIC §14000 et seq]

2) Makes adults and parents with incomes up to 138% of the federal poverty level (FPL) who are under age 65 eligible for Medi-Cal, and makes children with incomes up to 266% of the FPL eligible for Medi-Cal, including providing full-scope Medi-Cal benefits to undocumented children through age 18. [WIC §14005.60, 14005.64, 14005.27, 14005.64, and 14007.8]

3) Makes undocumented individuals ages 19 and above, who are otherwise eligible for Medi-Cal services, eligible only for care and services that are necessary for the treatment of an emergency medical condition and medical care directly related to the emergency, as defined in federal law. [WIC §14007.05]

4) Makes low-income undocumented individuals eligible for Medi-Cal for pregnancy coverage, breast and cervical cancer-related treatment services, family planning services and long-term care services. [WIC §24003, 14007.65, 14007.7, 14148, 14148.5, and 15832 and HSC §104162]

5) Defines, under state law, an "emergency medical condition" as a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

    a) Placing the patient's health in serious jeopardy;
    b) Serious impairment to bodily functions; or,
    c) Serious dysfunction of any bodily organ or part. [WIC §14007.05]

This bill:

1) Makes undocumented adults age 19 and older who meet all of the eligibility requirements for full-scope Medi-Cal benefits, except for their immigration status, eligible for full-scope Medi-Cal benefits.

2) Requires undocumented individuals already enrolled in limited scope Medi-Cal to be enrolled pursuant to an eligibility and enrollment plan, which includes outreach strategies developed by DHCS in consultation with interested stakeholders, including but not limited to counties, health plans, consumer advocates and the Legislature.

3) Requires undocumented individuals to enroll into Medi-Cal managed care health plans, and to pay copayments and premium contributions to the extent required of otherwise eligible Medi-Cal recipients who are similarly situated.

4) Requires DHCS to maximize federal financial participation in implementing these requirements to the extent allowable.

FISCAL EFFECT: This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) *Author's statement.* According to the author, over the last year, we have witnessed a barrage of attacks on health care from the federal government, including multiple efforts to repeal the Affordable Care Act (ACA), the elimination of the individual mandate penalty in the federal tax bill, and various administrative actions that undermine access to care. While California has worked to shield our state from these attacks, it is just as important to continue our progress toward universal coverage. California already provides near-universal coverage for children, thanks in large part to the Health4All Kids program, which provides publicly funded health coverage for undocumented children. SB 75 (2015) included an investment to expand full-scope Medi-Cal to all low-income children under the age of 19, regardless of immigration status. With the implementation of Health4All Kids on May 16, 2016, more than 218,000 undocumented children now receive comprehensive care. In 2017, I introduced SB 562, the Healthy California Act, to create one publicly funded healthcare system that covers all Californians regardless of their immigration status or income. Unfortunately, federal law explicitly and unjustly excludes undocumented adult immigrants from receiving full scope health coverage through Medi-Cal, and from selecting a health plan or receiving subsidies through Covered California. As a result, undocumented adults are still left without comprehensive health care. This bill removes a barrier to health access due to immigration status and brings California closer to ensuring that every Californian has comprehensive, affordable, and accessible care.

2) *Current scope of Medi-Cal coverage for immigrants*. In order to be Medi-Cal eligible, an individual must be a state resident and generally must be low-income. Recent legal immigrants and undocumented immigrants who meet income and residency requirements are Medi-Cal eligible, but the scope of that coverage depends on the immigration status of the immigrant and the age of the individual. Undocumented children were made eligible for full-scope Medi-Cal services pursuant to SB 75 (Committee on Budget and Fiscal Review, Chapter 18, Statutes of 2016) the health budget trailer bill. As of December 2017, a total of 218,571 undocumented children have enrolled in full-scope Medi-Cal, in two distinct populations:

a) *Restricted-scope Medi-Cal beneficiaries.* As of December 2017, 120,614 undocumented children previously enrolled in restricted-scope Medi-Cal coverage transitioned into full-scope Medi-Cal coverage; and,
b) *Not previously enrolled.* DHCS estimated 130,924 undocumented children that were eligible for, but not enrolled in, restricted-scope Medi-Cal were eligible for full-scope coverage under the expansion of eligibility. As of December 2017, 97,957 children in this category enrolled in full-scope benefits.

Undocumented immigrants age 19 and above are not eligible for full scope services, and are instead eligible for "limited scope" Medi-Cal benefits. Limited scope services are long-term care, pregnancy-related benefits, and emergency services. Medi-Cal also provides coverage for undocumented individuals needing breast and cervical cancer treatment, family planning services through Family PACT, and through temporary presumptive eligibility programs. Undocumented adults are not eligible (with very few exceptions) for enrollment in Medi-Cal managed care plans.

3) *The ACA and the remaining uninsured.* According to data from the Centers for Disease Control and Prevention (CDC), National Health Interview Survey, the rate of Californians without insurance has declined from 17.2% in 2012 to 6.8% in the first six months of 2017. According to preliminary data from data from the UC Berkeley Center for Labor Research and Education (UC Berkeley) and the UCLA Center for Health Policy Research (UCLA) for 2017, there are over three million remaining uninsured in California as follows:

California Projected Uninsured, Ages 0-64, 2017	Number	Percentage
Non-subsidy eligible citizens/lawfully present immigrants	550,000	18%
Eligible for subsidies through Covered California	401,000	13%
Eligible for Medi-Cal	322,000	11%
Not eligible due to immigration status	1,787,000	58%

According to the UC Berkeley and UCLA model, an estimated 1.2 to 1.3 million undocumented adults have income at or below 138% of the FPL (at or below $16,643 in 2017), including nearly one million enrolled in restricted scope Medi-Cal which covers emergency-and pregnancy-related services only.

4) *Related legislation.* AB 2965 (Arambula) is identical to this bill. *AB 2965 is pending hearing in the Assembly Committee on Health.*

5) *Prior legislation.* SB 10 (Lara, Chapter 22, Statutes of 2016) required Covered California (CC) to apply to the federal Department of Health and Human Services for a Section 1332 waiver to allow persons who are not otherwise able to obtain coverage through CC by reason of immigration status to obtain coverage from CC by waiving the requirement that CC offer only qualified health plans.

SB 4 (Lara, Chapter 709, Statutes of 2015) required undocumented individuals under 19 years of age enrolled in Medi-Cal at the time the Director of DHCS makes the determination to be enrolled in full scope of Medi-Cal benefits, if otherwise eligible, pursuant to an eligibility and enrollment plan.

SB 97 (Budget and Fiscal Review Committee, Chapter 11, Statutes of 2015) expanded eligibility for full-scope Medi-Cal benefits for undocumented children under the age of 19, regardless of immigration status.

SB 1005 (Lara of 2014) would have extended Medi-Cal eligibility to individuals who would otherwise be eligible, except for their immigration status, and would have created a new health benefit exchange, to provide subsidized health care coverage to individuals who cannot purchase health care coverage through CC due to their immigration status. *SB 1005 was held on the Senate Appropriations suspense file.*

AB X1 1 (Perez, Chapter 3, Statutes of 2013-14 First Extraordinary Session) implemented specified Medicaid provisions of the ACA, including the expansion of federal Medicaid coverage to low-income adults with incomes between 0-138% of the FPL. AB X1 1 also implemented a number of the Medicaid ACA provisions to simplify the eligibility, enrollment and renewal processes for Medi-Cal.

6) *Support*. This bill is jointly sponsored by Health Access California (Health Access) and the California Immigrant Policy Center (CIPC) and is supported by individuals, low-income, labor, consumer, health care providers, immigrant, religious, and community groups. Health Access writes this bill would bring California one step closer to universal coverage by making full-scope Medi-Cal available to all income-eligible adults regardless of immigration status. CIPC argues making Medi-Cal inclusive of all income-eligible Californians builds upon our state's leadership to advance universal coverage and ensure that no Californian is unjustly barred from access to health care. CIPC writes that almost two-thirds of undocumented Californians have lived in the United States for more than ten years, one in six of all California children have at least one undocumented parent, and undocumented Californians play a significant role in the workforce and the state's economy but are four times more likely to be uninsured than their US citizen counterparts. CIPC writes that despite their critical role in our society and state, undocumented and uninsured Californians are locked out of access to comprehensive health care. Health Access argues Californian's health system and Californians in general are healthier and stronger when everyone is included, and that when every Californian has the opportunity to have affordable comprehensive health coverage, they have access to preventive, primary and ongoing care as well as financial security against medical debt and bankruptcy.

SUPPORT AND OPPOSITION:

Support: Health Access California (co-sponsor)
California Immigrant Policy Center (co-sponsor)
Alianza
Alliance San Diego
American Civil Liberties Union of California Center for Advocacy and Policy
American Friends Service Committee's US-Mexico Border Program
API Equality-LA
APLA Health
Asian Americans Advancing Justice
Asian Law Alliance
ASPIRE
California Advocates for Nursing Home Reform
California Asset Building Coalition
California Black Health Network

California Coverage & Health Initiatives
California Food Policy Advocates
CaliforniaHealth+ Advocates
California Health Professional Student Alliance
California Immigrant Policy Center
California Labor Federation
California Latinas for Reproductive Justice
California OneCare
California Pan-Ethnic Health Network
California Partnership
California Physicians Alliance
California Rural Legal Assistance Foundation
California Teamsters
California Voices for Progress
Children's Defense Fund-California
Children Now
Clinica Monsenor Oscar A. Romero Community Health Centers
Coalition for Humane Immigrant Rights
Community Health Alliance of Pasadena (ChapCare's)
Community Health Councils
Community Health Initiative or Orange County
Community Health Partnership of Santa Clara and San Mateo Counties
Dream Team Los Angeles
Essential Access Health
Friends Committee on Legislation of California
Greenlining Institute
Having Our Say Coalition
Indivisible CA StateStrong
Inland Empire Coverage and Health Collaborative
Inland Empire-Immigrant Youth Collective
Jus Semper Global Alliance
Justice in Aging
Latino Coalition for a Healthy California
Law Foundation of Silicon Valley
Long Beach Immigrant Rights Coalition
Los Angeles Dependency Lawyers
Los Angeles LGBT Center
Lutheran Office of Public Policy-California
Maternal and Child Health Access
Merced Lao Family Community, Inc.
Mixteco/Indigena Community Organizing Project
Multi-faith ACTION Coalition
National Council of Jewish Women
National Health Law Program
National Immigration Law Center
PICO California
San Diego Immigrant Rights Consortium
San Diego Organizing Project
San Francisco AIDS Foundation
San Francisco Senior & Disability Action

SEIU California
Services, Immigrant Rights, and Education Network
South Asian Network
Southeast Asia Resource Action Center
South Bay People Power
Street Level Health Project
St. Anthony Foundation
St. John's Well Child & Family Center
The Children's Partnership
TODEC Legal Center
Tri-Valley Progressives for Our Revolution
United Cambodian Community
United Ways of California
Western Center on Law and Poverty
Young Invincibles

Oppose: None received

-- END --

Contra Costa County Board of Supervisors

Subcommittee Report

LEGISLATION COMMITTEE **10.**

Meeting Date:	05/14/2018
Subject:	SB 1105 (Skinner): Vehicles: Driving Offenses: Prosecution
Submitted For:	LEGISLATION COMMITTEE,
Department:	County Administrator
Referral No.:	2018-16
Referral Name:	SB 1105
Presenter:	Donte Blue **Contact:** L. DeLaney, 925-335-1097

Referral History:

SB 1105 by Senator Nancy Skinner would extend existing laws relating to the dismissal of Vehicle Code violations pending at the time of a defendant's commitment to state prison or county jail on a jail-eligible felony to provide the same relief to persons sentenced to county jail or other alternatives to incarceration.

The Deputy Director of the Office of Reentry and Justice recommends that the Committee consider recommending a position of "Support" to the Board of Supervisors on SB 1105.

Author:	Nancy Skinner (D-009)
Title:	Vehicles: Driving Offenses: Prosecution
Fiscal Committee:	yes
Urgency Clause:	no
Introduced:	02/13/2018
Last Amend:	04/03/2018
Disposition:	Pending
Location:	Senate Appropriations Committee
Summary:	Extends a specified immunity from prosecution and the prohibitions regarding suspending a driver's license to a person who completes a certain sentence work alternative program as a condition of probation. Makes these protections applicable to an offense committed while the person is temporarily released from custody, or an parole or postrelease community supervision. Authorizes incarcerated or previously convicted persons to request relief directly through the courts.

Referral Update:

The text of the bill can be found here:
http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180SB1105

CSAC currently has a "Watch" position on the bill.

The bill analysis is included in **Attachment A**.

Recommendation(s)/Next Step(s):

CONSIDER recommending to the Board of Supervisors a position of "Support" on SB 1105 (Skinner) and directing staff to put the bill on the Board's agenda for consent.

Fiscal Impact (if any):

Unknown.

Attachments

Attachment A: Bill Analysis

SENATE COMMITTEE ON APPROPRIATIONS
Senator Ricardo Lara, Chair
2017 - 2018 Regular Session

SB 1105 (Skinner) - Vehicles: driving offenses: prosecution

Version: April 3, 2018
Urgency: No
Hearing Date: April 23, 2018
Policy Vote: PUB. S. 5 - 2
Mandate: No
Consultant: Shaun Naidu

This bill meets the criteria for referral to the Suspense File.

Bill Summary: SB 1105 would allow for the dismissal of specified non-felony offenses pending against a person who has completed a commitment to county jail, as specified, or alternative program, as specified.

Fiscal Impact:

- Unknown, potentially-significant foregone revenue to the extent that outstanding fines, fees, and assessments are forgiven but would have been collected. (General Fund, various special funds, local funds) Revenue loss to counties would be offset in reduced workload for district attorneys' offices and public defenders' offices not having to prosecute and defend against, respectively, the dismissed charges.

  For example, Penal Code section 1465.7 imposes a 20 percent surcharge on every base fine resulting from a criminal conviction, with the revenue collected being allocated to the state General Fund. The default misdemeanor punishment includes a maximum base fine of $1,000. If 250 individuals who would have misdemeanor charges that are pending against them dismissed under this measure but otherwise would have been convicted and sentenced to pay the maximum base fine, the state General Fund would incur a loss of $50,000 from that one surcharge alone.

- The Department of Motor Vehicles anticipates programming costs of over $150,000 to implement changes to its IT system to accommodate a six-digit code section to monitor. (Motor Vehicle Account).

- Unknown loss of revenue to the court in the dismissal of civil assessments for a person who fails to pay all or a portion of a fine or fails to appear for a hearing or other proceeding. (Trial Court Trust Fund) This loss in revenue would be offset, in part, by the reduced workload to the court by not having to adjudicate the dismissed charges.

Background: Under existing law, once a person is committed to incarceration for a felony offense, any prosecution for a misdemeanor or infraction offense arising out of the operation of a vehicle or violation of the Vehicle Code as a pedestrian that is pending against him or her at the time of commitment is dismissed. Similarly, the driver license of that person cannot be suspended, revoked, or application therefor denied, as a result of a non-felony offense pending against him or her at the time of commitment that occurred prior to the time of commitment or as a result of a failure to appear notice received by DMV. The Department of Motor Vehicles is required to remove from its

records a failure to appear notice upon receipt of satisfactory evidence that a person was committed to state prison, the Division of Juvenile Justice (DJJ), or county jail pursuant to the 2011 Realignment Legislation.

Proposed Law: This bill would:

- Extend the above immunity from prosecution and the prohibitions regarding suspending the person's driver's license to a person upon completion of a sentence of seven days or longer in a county jail, work alternative program, or other alternative to incarceration as a condition of probation.
- Make the above protections applicable to an offense committed while the person is temporarily released from custody or on parole or post-release community supervision.
- Make a person immune from prosecution for an outstanding infraction or failure to appear, from liability for any unpaid fine or assessments, and from having his or her driver's license affected, once the person has been incarcerated for a cumulative thirty or more days in jail in any consecutive twelve-month period subsequent to the date of the violation.
- Allow an incarcerated, previously-incarcerated, or previously-convicted person to request the above-described relief directly through DMV or the court and would prescribe the duties of the department and the court in that regard.

Related Legislation: AB 877 (Skinner, 2011) would have expanded immunity from prosecution for non-felony Vehicle Code violations pending at the time of a person's commitment to state prison and expanded the prohibition against the suspension or revocation of a driver's license for a pending non-felony offense or as a result of a notice received for failure to appear that occurred prior to incarceration in state prison, to include an individual who has served ninety days or longer in a consecutive twelve-month period in a county jail or other county correctional facility, court or county rehabilitation facility, or involuntary in-home detention. AB 877 was held on the Suspense File of this Committee.

AB 3569 (Becerra, Ch. 950, Stats. 1992) exempted pending driving-under-the-influence and reckless driving offenses from immunity from prosecution while a person is committed to state prison or what is now known as DJJ.

-- END --

Contra Costa County Board of Supervisors

Subcommittee Report

LEGISLATION COMMITTEE **11.**

Meeting Date: 05/14/2018

Subject: Regional Housing Needs Allocation Bills SB 828 (Wiener) and AB 1771 (Bloom)

Submitted For: LEGISLATION COMMITTEE,

Department: County Administrator

Referral No.: 2018-15

Referral Name: Regional Housing Needs Allocation Bills

Presenter: L. DeLaney & C. Christian **Contact:** L. DeLaney, 925-335-1097

Referral History:

CSAC has been working with UCC and RCRC and a technical working group of planners from the California County Planning Directors Association to provide feedback and discuss potential amendments to two bills which both seek to recast California's regional housing needs process. The bills would touch on both the process for determining regional housing needs and the allocation of those regional needs among individual jurisdictions.

There have been recurrent policy discussions of linking state funding for various purposes to local government "compliance" with regional housing needs goals. Local governments have argued correctly that the mandate in the regional housing needs law is to *plan and zone for housing*, while linking funding to issuance of building permits as compared to allocations of land zoned for housing ignores many factors beyond local government control.

Accordingly, CSAC is interested in ensuring that any changes to the RHNA process: 1) result in more realistic allocations of planned growth for unincorporated counties, 2) support other state policy objectives (promoting infill, etc), and 3) recognize that is fundamentally a planning and zoning requirement.

Detailed information on remaining issues and requests for comments on the two RHNA-related bills, SB 828 and AB 1771, is provided below. This legislation will be discussed at the **CSAC Housing, Land Use and Transportation Policy Committee meeting on Thursday, May 17 at 8:45 AM**. The presentation will include analysis by CSAC on current housing needs allocations with a focus on unincorporated county allocations.

Referral Update:

- **SB 828 (Wiener)** was heard for the first time in the Senate Transportation and Housing Committee on April 26. The committee asked for three amendments, which are now in print (see: http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180SB828):

- *Rezoning* sites for 125% of allocation by income (vs. 200%) in Sec. 1 (CSAC is interested in feedback on this change);

- Change "shall" to "should" in the language concerning broad purpose of RHNA in Sec. 2 (According to CSAC staff, the new language is an improvement, but is still problematic.); and

- Remove the reference to "filtering" in Sec. 5 (Section 65584.04(i)(5)(B)).

- In addition to these amendments, the author had to commit to working with the chair and stakeholders, including councils of government, counties, and cities. CSAC, RCC and UCC met with Senator Wiener's office and the committee consultant on to reiterate CSAC concerns as well as potential shared goals (i.e. realistic allocations focused in areas with high demand for housing).

- A CSAC/UCC/RCRC "concerns" letter on SB 828 is available online here: http://blob.capitoltrack.com/17blobs/5d888a9c-f8de-494e-9cf2-4fd0f5ede030. This letter outlines some of CSAC's general principals on RHNA. CSAC's future correspondence will focused on more specific language changes. Depending on the willingness of the author to address the concerns outlined below, the position may move from "concerns" to "oppose unless amended."

- **Remaining issues with SB 828 and Requests for Comments**

- **Clarifying RHNA intent language** to ensure that RHNA remains a planning tool and recognizes that, despite zoning, there are many factors beyond local government control that contribute to whether housing is produced or not *(Section 65584(a)(2))*.

- **Rezoning to Meet Adequate Sites:** Appropriate standard for rezoning when adequate sites are not identified in housing element (the "125%" issue) and how this links to SB 166 (Skinner, 2017); consideration of the "developed areas" language, whether this is appropriate, and how it links to AB 1397 (Low, 2017) *(Section 65583(c)(1))*.

- **HCD housing backlog "audit"** – CSAC staff thinks this is highly likely to be amended out of the bill in Appropriations (or cause the bill to be held), but are seeking feedback. CSAC might like to see it removed no matter what, or perhaps limit it to metropolitan counties *(Section 65584.01.1)*.

- **The unappealable "deficit rollover"** – The associations are arguing that this provision is entirely unworkable; that it doubles-down on current unrealistically large allocations to unincorporated areas; that it fails to account for entitled but unbuilt projects; that it

encourages zoning for sprawl, especially in jurisdictions where housing demand is low; and that it is unnecessary if broader problems with regional assessments and jurisdictional allocations are addressed *(Section 65584.01.(c)(4))*. This general issue was raised by several members and the Chair of the Senate Transportation and Housing Committee.

- **Regional Assessment Factors:** Ensuring that the appropriate factors are added to the criteria for regional housing needs assessment—CSAC would appreciate feedback on other factors that may need to be considered by HCD/COGs. While some of the factors included in the bill will likely promote allocations that are more realistic with unincorporated areas and better aligned with employment and the state's infill goals, some factors seem unrealistic (e.g. 6% rental vacancy rate) *(Section 65584.01(b)(1)(A-H))*.

- **Allocation Plan Factors:** Ensuring that the appropriate factors are included in the criteria for the jurisdictional allocations of the region's housing needs – again would appreciate feedback on these factors. Note that CSAC also recognizes the need for general clean up new language in this subdivision: What is a "high" allocation? How can an allocation plan "demonstrate" that it will reverse racial and wealth disparities? Etc. *(Section 65584.04(i)(1-5)*.

- **AB 1771 (Bloom)** was also heard in policy committee this week. The most recent text is available online here: http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180AB1771

- CSAC, UCC and RCRC have not issued a letter on this bill yet, but are interested in your feedback on the following issues:

- **Allocation Plan Objectives:** Ensuring that the appropriate objectives are included in the criteria for the jurisdictional allocations of the region's housing needs *(Section 65584(d-f))*.

- **Factors for Allocation Methodology:** Ensuring that appropriate factors are considered in the allocation methodology developed by the COGs, and the appropriate role for HCD in determining whether or not the methodology furthers, and does not undermine, the objectives in 65584(d) *(Section 65584.04(d))*.

- **Appeals Process:** Appropriateness of adding an opportunity for "housing groups" to appeal one or more jurisdiction's allocation of the regional housing need and other changes to the appeals process in Section 3 of the bill *(Section 65584.05(a-j))*. *Note: an alternative approach under consideration by some opponents of the bill would be to limit the grounds on which a local agency can appeal its allocation rather than creating a new appeals process.*

Recommendation(s)/Next Step(s):

PROVIDE feedback to staff on SB 828 (Weiner) and AB 1771 (Bloom): Planning and Zoning: Regional Housing Needs Assessment, which will be provided to CSAC staff as requested.

Attachments

No file(s) attached.

Contra Costa County Board of Supervisors

Subcommittee Report

LEGISLATION COMMITTEE **12.**

Meeting Date: 05/14/2018

Subject: Support for HR 5003, a Bill to Restore Advance Refundings of Tax-Exempt Bonds

Submitted For: LEGISLATION COMMITTEE,

Department: County Administrator

Referral No.: 2018-13

Referral Name: Support for HR 5003

Presenter: Timothy Ewell **Contact:** Timothy Ewell, (925) 335-1036

Referral History:

The Board of Supervisors' Federal Legislative Platform currently includes several items concerning tax-exempt municipal bonds. Most notably, the Board has taken a position supporting generally the preservation of municipal bonds.

Recently, the Tax Cuts and Jobs Act of 2017 (the "Tax Bill") discontinued authorization for state and local governments to issue "advance refunding" bonds, which previously allows jurisdictions to refinance current debt at reduced interest rates. This was, in part, due to the belief that such authorization essentially allowed for "double dipping" by state and local entities. This was bolstered by reports from the Joint Committee on Taxation (the "JCT") that advance refundings are projected to by a tax expenditure to the federal government of $17.3 billion over the ten-year period 2018-2027.

In Contra Costa County, advance and current refunding bonds have been used to refund existing bonds resulting in significant cost savings locally. As noted in the chart below, over the past 15 years, the County has realized $23.3 million in net present value (NPV) savings amounting to approximately $2.1 million per year. This would not have been possible, in part, but for advance refunding bonds. Therefore, the Chief Assistant County Administrator, Tim Ewell, referred this item to the Committee for its consideration of a position of "Support" to the Board of Supervisors.

Lease Revenue Bond Refunding Savings Since 2002
(as of June 30, 2017)

Refunding Lease Revenue Bond Issue	Amount Refunded ($ millions)	Term of the Refunding Bonds	Savings ($ millions)	Average Annual Savings
2002 Series B	$25.870	18 years	$0.85	$49,906
2007 Series A (advance refunding)	61.220	21 years	3.83	182,380
2007 Series A (current refunding)	26.815	14 years	0.90	64,286
2007 Series B	112.845	15 years	2.93	195,333
2010 Series B (current refunding)	17.400	15 years	1.10	73,330
2015 Series B (advance and current refunding)	55.995	13 years	4.58	416,893
2017 Series A	117.030	10 years	9.10	1,105,113
Total	***$417.175***		***$23.29***	***$2,087,241***

Referral Update:

On February 13, 2018, members of the bi-partisan House Municipal Finance Caucus, Co-Chaired by Representatives Hultgren and Ruppersberger introduced H.R. 5003 (**Attachment A**) with the goal of reinstating advance refunding bonds. Currently, the bill has bipartisan support of ten (10) co-sponsors and has been referral to the House Ways and Means Committee.

On Monday, May 7, 2018, several national organizations representing public-sector entities that issue tax-exempt debt to finance infrastructure projects, including the National Association of Counties (NACo), the National League of Cities and the U.S. Conference of Mayors, joined in a letter (**Attachment B**) to members of Congress offering support for H.R. 5003. The letter outlines the importance of advance refunding bonds as a tool in the municipal bond market and calls on members of Congress to sign on as co-sponsors to the bill.

Recommendation(s)/Next Step(s):

CONSIDER recommending a position of “Support” to the Board of Supervisors for H.R. 5003 to amend the Internal Revenue Code of 1986 to reinstate advance refunding bonds; authorize the Chair of the Board to send a letter to members of the House of Representatives representing Contra Costa County requesting co-sponsorship of the bill; direct staff to amend the County's adopted federal legislative platform to make conforming changes.

Attachments

Attachment A: HR 5003

Attachment B: Support Letter

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115TH CONGRESS
2D SESSION

H. R. 5003

To amend the Internal Revenue Code of 1986 to reinstate advance refunding bonds.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 13, 2018

Mr. HULTGREN (for himself, Mr. RUPPERSBERGER, Mr. MESSER, Mr. ROYCE of California, Mr. KILDEE, and Mr. CAPUANO) introduced the following bill; which was referred to the Committee on Ways and Means

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A BILL

To amend the Internal Revenue Code of 1986 to reinstate advance refunding bonds.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. TREATMENT OF ADVANCE REFUNDING BONDS.

(a) IN GENERAL.—Section 149(d) of the Internal Revenue Code of 1986 is amended—

(1) in paragraph (1), by striking ''to advance refund another bond'' and inserting ''as part of an issue described in paragraph (2), (3), or (4)'';

(2) by redesignating paragraphs (2) and (3) as paragraphs (6) and (7), respectively; and

(3) by inserting after paragraph (1) the following new paragraphs:

"(2) CERTAIN PRIVATE ACTIVITY BONDS.—An issue is described in this paragraph if any bond (issued as part of such issue) is issued to advance refund a private activity bond (other than a qualified 501(c)(3) bond).

"(3) OTHER BONDS.—

"(A) IN GENERAL.—An issue is described in this paragraph if any bond (issued as part of such issue), hereinafter in this paragraph referred to as the 'refunding bond', is issued to advance refund a bond unless—

"(i) the refunding bond is only—

"(I) the 1st advance refunding of the original bond if the original bond is issued after 1985, or

"(II) the 1st or 2nd advance refunding of the original bond if the original bond was issued before 1986,

"(ii) in the case of refunded bonds issued before 1986, the refunded bond is redeemed not later than the earliest date on which such bond may be redeemed at par or at a premium of 3 percent or less,

"(iii) in the case of refunded bonds issued after 1985, the refunded bond is redeemed not later than the earliest date on which such bond may be redeemed,

"(iv) the initial temporary period under section 148(c) ends—

"(I) with respect to the proceeds of the refunding bond not later than 30 days after the date of issue of such bond, and

"(II) with respect to the proceeds of the refunded bond on the date of issue of the refunding bond, and

"(v) in the case of refunded bonds to which section 148(e) did not apply, on and after the date of issue of the refunding bond, the amount of proceeds of the refunded bond invested in higher yielding investments (as defined in section 148(b)) which are nonpurpose investments (as defined in section 148(f)(6)(A)) does not exceed—

"(I) the amount so invested as part of a reasonably required reserve

or replacement fund or during an allowable temporary period, and

"(II) the amount which is equal to the lesser of 5 percent of the proceeds of the issue of which the refunded bond is a part or $100,000 (to the extent such amount is allocable to the refunded bond).

"(B) SPECIAL RULES FOR REDEMPTIONS.—

"(i) ISSUER MUST REDEEM ONLY IF DEBT SERVICE SAVINGS.—Clause (ii) and (iii) of subparagraph (A) shall apply only if the issuer may realize present value debt service savings (determined without regard to administrative expenses) in connection with the issue of which the refunding bond is a part.

"(ii) REDEMPTIONS NOT REQUIRED BEFORE 90TH DAY.—For purposes of clauses (ii) and (iii) of subparagraph (A), the earliest date referred to in such clauses shall not be earlier than the 90th day after the date of issuance of the refunding bond.

"(4) ABUSIVE TRANSACTIONS PROHIBITED.—An issue is described in this paragraph if any bond (issued as part of such issue) is issued to advance refund another bond and a device is employed in connection with the issuance of such issue to obtain a material financial advantage (based on arbitrage) apart from savings attributable to lower interest rates.

"(5) SPECIAL RULES FOR PURPOSES OF PARAGRAPH (3).—For purposes of paragraph (3), bonds issued before the date of the enactment of this subsection shall be taken into account under subparagraph (A)(i) thereof except—

"(A) a refunding which occurred before 1986 shall be treated as an advance refunding only if the refunding bond was issued more than 180 days before the redemption of the refunded bond, and

"(B) a bond issued before 1986, shall be treated as advance refunded no more than once before March 15, 1986.".

(b) CONFORMING AMENDMENT.—Section 148(f)(4)(C) of such Code is amended by redesignating clauses (xiv) through (xvi) as clauses (xv) through (xvii)

and by inserting after clause (xiii) the following new clause:

"(xiv) DETERMINATION OF INITIAL TEMPORARY PERIOD.—For purposes of this subparagraph, the end of the initial temporary period shall be determined without regard to section 149(d)(3)(A)(iv).".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to advance refunding bonds issued after the date of the enactment of this Act.

○

Government Finance Officers Association
National Governors Association
National Association of State Treasurers
Council of State Governments
National Conference of State Legislatures
The United States Conference of Mayors
National Association of Counties
National League of Cities
International City/County Management Association
Airports Council International – North America
National Association of Towns and Townships
National Association of State Auditors, Comptrollers and Treasurers
American Association of Port Authorities
American Hospital Association
American Planning Association
American Public Power Association
American Public Works Association
American Society of Civil Engineers
American Water Works Association
Association of Public and Land-grant Universities
Association of Metropolitan Water Agencies
WateReuse Association
National Association of Clean Water Agencies
Council of Infrastructure Financing Authorities
International Public Management Association for Human Resources
Large Public Power Council
National Association of Municipal Advisors
National Association of Bond Lawyers
National Association of College and University Business Officers
National Association of Health and Educational Facilities Finance Authorities
National Association of Regional Councils
National Community Development Association
National Association of Local Housing Finance Agencies

May 7, 2018

VIA Electronic Mail

RE: Request Co-sponsorship of HR 5003 to Amend the Internal Revenue Code of 1986 to Restore Advance Refunding

Dear Member of Congress:

The national organizations listed above represent hundreds of thousands of public-sector entities that issue debt to finance and build the infrastructure that contributes to strong economies at the state and local levels across the country. Our collective memberships support the need for legislation that would reinstate authority to advance refund municipal bonds. We also ask that you join as a co-sponsor of H.R. 5003, a

bipartisan bill to restore this federal tax code provision that for decades saved local taxpayers billions in interest expense.

Under previous law, governmental bonds and 501(c)(3) bonds issued by state and local governments were permitted a single advance refunding. This allowed public issuers to take advantage of reductions in interest rates to realize billions of dollars in savings, which ultimately benefits taxpayers. In fact, the Government Finance Officers Association (GFOA) best practices recommended an advance refunding should produce a minimum savings threshold on a present value basis of 3-5 percent. In the last 5 years, 2013-2017, the advance refunding of municipal securities saved taxpayers at least $12 billion, a benefit to all of our shared constituencies. It is the practice of state and local governments to measure savings on a present value basis but it is worth noting that the actual savings resulting from these advance refundings is far in excess of $12 billion in present value savings.

Since tax-exempt advance refundings were prohibited, municipal bond market activity has declined significantly, creating less supply for the very strong demand that exists for municipal securities from retail and institutional investors. In Q1 2017 volume was $92 billion compared to Q1 2018 just $65 billion, a decrease in 30%. The bond market underpins the strength of state and municipal governments to provide necessary infrastructure across the United States.

Thank you for considering this important legislation. We look forward to working with you and supporting the effort to help the public issuer community on this vital issue.

Sincerely,

Government Finance Officers Association, Emily Swenson Brock, 202-393-8467
Airports Council International – North America, Annie Russo, 202-293-4544
American Association of Port Authorities, Susan Monteverde, 703-684-5700
American Hospital Association, Mike Rock, 202-638-1100
American Planning Association, Jason Jordan, 202-349-1005
American Public Power Association, John Godfrey, 202-467-2929
American Public Works Association, Andrea Eales, 202-218-6730
American Society of Civil Engineers, Brian Pallasch, 202-789-7852
American Water Works Association, Tommy Holmes, 202-326-3128
Association of Metropolitan Water Agencies, Diane VanDe Hei, 202-331-2820
Association of Public and Land-grant Universities, Craig Lindwarm, 202-478-6032
Council of Infrastructure Financing Authorities, Rick Farrell, 202-547-1866
Council of State Governments, Andy Karellas, 202-624-5460
International City/County Management Association, Elizabeth Kellar, 202-962-5328
International Public Management Association for Human Resources, Neil Reichenberg, 703-549-7100
Large Public Power Council, Noreen Roche-Carter, 916-732-6509
National Assoc. of Health and Educational Facilities Finance Authorities, Chuck Samuels, 202-434-7311
National Association of Bond Lawyers, Jessica Giroux, 202-503-3303
National Association of Clean Water Agencies, Kristina Surfus, 202-833-4655
National Association of College and University Business Officers, Elizabeth Clark, 202-861-2553
National Association of Counties, Jack Peterson, 202-661-8805
National Association of Local Housing Finance Agencies, Heather Voorman, 202-367-2405
National Association of Municipal Advisors, Susan Gaffney, 703-395-4896
National Association of Regional Councils, Leslie Wollack, 202-618-6363
National Association of State Auditors, Comptrollers and Treasurers, Cornelia Chebinou, 202-624-5451
National Association of State Treasurers, Shaun Snyder, 202-744-6663

National Association of Towns and Townships, Jennifer Imo, 202-454-3947
National Community Development Association, Vicki Watson 202-656-9552
National Conference of State Legislatures, Max Behlke, 202-624-3586
National Governors Association, Caroline Sevier, 202-624-5376
National League of Cities, Brian Egan, 202-626-3107
The United States Conference of Mayors, Larry Jones, 202-861-6709
WateReuse Association, Amber Kim, 571-445-5504