SENATE JUDICIARY COMMITTEE
Senator Thomas Umberg, Chair
2023-2024 Regular Session

AB 616 (Rodriguez)
Version: July 6, 2023
Hearing Date: July 11, 2023
Fiscal: Yes
Urgency: No
AM

SUBJECT

Medical Group Financial Transparency Act

DIGEST

This bill authorizes the public disclosure of audited financial reports and comprehensive financial statements of providers and physician organizations collected by the Office of Health Care Affordability (OHCA) and financial and other records of risk-bearing organizations made available to the Department of Managed Health Care (DMHC), as provided.

EXECUTIVE SUMMARY

California consumers, businesses, and the state budget are being burdened by the rising cost of health care. In 2021, half of Californians skipped or delayed health care due to concerns about cost, and the cost of care is the most commonly cited reason for Californians to be uninsured or underinsured.[1] California has taken steps to address this issue, most recently in 2022 when OHCA was established. OHCA was tasked with the responsibility of collecting information from health care providers and entities in order to understand the factors driving rising prices. Additionally, the DMHC collects certain data regarding risk-bearing organizations (RBOs) in order to review or grade RBOs. Under existing law, OHCA and DMHC are prohibited from disclosing that information to the public. This bill aims to provide greater transparency into health care spending by requiring public disclosure of that data. The proponents of the bill believe this will assist policymakers, advocates, and academics to inform policy proposals and help them understand how changes to existing policy can impact affordability, access, and quality of care.

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[1] Kristen Hwang and Ana B. Ibarra, *Health care costs keep rising. A new California agency aims to fix that* (July 15, 2022), available at https://calmatters.org/health/2022/07/rising-health-care-costs/.

The bill is sponsored by Service Employee International Union California (SEIU). It is supported by various labor organizations and public health and health care advocacy organizations. The bill is opposed by various associations representing medical providers and medical entities whose information would be publically disclosed under this bill. The bill passed the Senate Health Committee on a vote of 9 to 1.

PROPOSED CHANGES TO THE LAW

Existing law:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) and the California Department of Insurance (CDI) to regulate health insurance. (Health & Saf. Code § 1340, et seq.; Ins. Code § 106, et seq.)

2) Defines a "risk-bearing organization or RBO" to mean a professional medical corporation, other form of corporation controlled by physicians and surgeons, a medical partnership, a medical foundation exempt from licensure, as specified, or another lawfully organized group of physicians that delivers, furnishes, or otherwise arranges for or provides health care services, but does not include an individual or a health plan, that also:
    a) contracts directly with a health plan or arranges for health care services for the health plan's enrollees;
    b) receives compensation for those services on any capitated or fixed periodic payment basis; and
    c) is responsible for the processing and payment of claims made by providers for services rendered by those providers on behalf of a health plan that are covered under the capitation or fixed periodic payment made by the plan to the RBO. This does not limit, alter, or abrogate any responsibility of a health plan under existing law. (Health & Saf. Code § 1375.4.)

3) Requires every contract between a health plan and a RBO to include provisions concerning the RBO's administrative and financial capacity, such as:
    a) a requirement that the RBO furnish financial information to the health plan or the plan's designated agent and meet any other financial requirements that assist the health plan in maintaining the financial viability of its arrangements for the provision of health care services in a manner that does not adversely affect the integrity of the contract negotiation process;
    b) a requirement that the health plan disclose information to the RBO that enables the RBO to be informed regarding the financial risk assumed under the contract; and

  c) a requirement that the health plan provide payments of all risk arrangements, excluding capitation, within 180 days after close of the fiscal year. (Health & Saf. Code § 1375.4.)

4) Requires DMHC to provide a process for reviewing or grading RBOs based on specified criteria and requires these balance sheets, claims reports, and designated annual, quarterly, or monthly financial statements to be prepared and audited in accordance with generally accepted accounting principles, and used in a manner, and to the extent necessary that it does not adversely affect the integrity of the contract negotiation process between the health plan and the RBO. (Health & Saf. Code § 1375.4.)

5) Requires reports of all examinations of the fiscal and administrative affairs of any health care service plan, and each person with whom the plan has made arrangements for administrative, management, or financial services, to be open to public inspection, except that no examination is to be made public, unless the plan has had an opportunity to review the examination report and file a statement or response within 45 days of the date that DMHC provided the report to the plan.
   a) After reviewing the plan's response, the Director of DMHC is required to issue a final report that excludes any survey information, legal findings, or conclusions determined by the director to be in error, describes compliance efforts, identifies deficiencies that have been corrected by the plan on or before the time the director receives the plan's response, and describes remedial actions for deficiencies requiring longer periods for the remedy required by the director or proposed by the plan. (Health & Saf. Code § 1382.)

6) Establishes the Department of Health Care Access and Information (HCAI), which among many other responsibilities, collects and publicly reports health data, including health facility financial data. (Health & Saf. Code § 128675–128810.)

7) Requires an organization that operates, conducts, owns, or maintains a health facility to make and file all of the following reports with HCAI:
   a) a balance sheet detailing the assets, liabilities, and net worth of the health facility at the end of its fiscal year;
   b) a statement of income, expenses, and operating surplus or deficit for the annual fiscal period, and a statement of ancillary utilization and patient census;
   c) a statement detailing patient revenue by payer, including, but not limited to, Medicare, Medi-Cal, and other payers, and revenue center;
   d) a statement of cash flows, including, but not limited to, ongoing and new capital expenditures and depreciation; and

e) a statement reporting the information required in a)-d), above, for each separately licensed health facility operated, conducted, or maintained by the reporting organization. (Health & Saf. Code § 128735.)

8) Authorizes a health facility that receives a preponderance of its revenue from associated comprehensive group practice prepayment health plans and that is operated as a unit of a coordinated group of health facilities under common management to report the information required pursuant to a) and d) above for the coordinated group of health facilities, and not for each separately licensed health facility. (Health & Saf. Code § 128735.)

9) Establishes the Office of Health Care Affordability (OHCA) within HCAI with the responsibility to analyze the health care market for cost trends and drivers of spending, developing data-informed policies for lowering health care costs for consumers and purchasers, creating a state strategy for controlling the cost of health care and ensuring affordability for consumers and purchasers, and enforcing cost targets. (Health & Saf. Code § 127501.)

10) Requires OHCA, notwithstanding any other state or local law, to collect data and other information it determines necessary from health care entities and providers, except exempted providers who are determined exempt by the standards developed by the OHCA board.
    a) Authorizes OHCA to use existing and emerging public and private data sources to minimize administrative burdens and duplicative reporting, including data or information from federal agencies as well as state agencies.
    b) Authorizes OHCA to request data and information from, or enter into a data sharing agreement with state agencies that collect payer and provider financial data. (Health & Saf. Code § 127501.4.)

11) Requires OHCA to require providers, except exempted providers who are determined by the standards for exemption developed by the OHCA board, and any physician organizations that are part of a fully integrated delivery system to submit audited financial reports, similar to those required in 7), above.
    a) Requires OHCA to require providers that do not routinely prepare audited financial reports, to require a comprehensive financial statement that includes details regarding annual costs, annual receipts, realized capital gains and losses, and accumulated surplus and accumulated reserves using the standard accounting method routinely used by the physician organization or provider.
    b) Requires the comprehensive financial statement to be supported by sworn written declarations by an officer who has management and oversight responsibilities for the physician organization or provider, certifying that the financial statement is complete, true, and correct in all material

matters to the best of their knowledge, and that the provider does not routinely prepare audited financial reports. (Health & Saf. Code § 127501.4.)

12) Prohibits, notwithstanding any other law, all information and documents obtained in 11), above, from being required to be disclosed pursuant to the California Public Records Act. Requires the OHCA board, OHCA, HCAI, employees, contractors, and advisors of OHCA and HCAI to keep the audited financial reports and comprehensive financial statements confidential, and to use the confidential information and documents only as necessary for the function of OHCA. (Health & Saf. Code § 127501.4.)

13) Provides, pursuant to the California Constitution, that the people have the right of access to information concerning the conduct of the people's business, and, therefore, the meetings of public bodies and the writings of public officials and agencies are required to be open to public scrutiny. (Cal. const. art. I, § 3(b)(1).)
    a) Requires a statute to be broadly construed if it furthers the people's right of access, and narrowly construed if it limits the right of access. (Cal. const. art. I, § 3(b)(1).)

14) Governs the disclosure of information collected and maintained by public agencies pursuant to the California Public Records Act (CPRA). (Gov. Code §§ 7920.000 et seq.)
    a) States that the Legislature, mindful of the individual right to privacy, finds and declares that access to information concerning the conduct of the people's business is a fundamental and necessary right of every person in this state. (Gov. Code § 7921.000.)
    b) Defines "public records" as any writing containing information relating to the conduct of the public's business prepared, owned, used, or retained by any state or local agency regardless of physical form or characteristics. (Gov. Code § 7920.530.)
    c) Provides that all public records are accessible to the public upon request, unless the record requested is exempt from public disclosure. (Gov. Code § 7922.530.)

This bill:

1) Requires, notwithstanding any other law, financial and other records of RBOs to be produced, disclosed, or otherwise made available to DMHC, as specified, to be open to public disclosure using a process equivalent to the process for disclosing health plan financial and administrative information described in Section 1382 of the Health and Safety Code. This is not to be construed to require the public disclosure of individual plan specific rates or revenues.

2) Requires audited financial reports or comprehensive financial statements produced, disclosed, or otherwise made available by physician organizations comprised of 50 or more physicians to be publicly disclosed by OHCA using a process equivalent to the process for public disclosure of health facility information submitted pursuant to subdivisions (a) to (e) of Section 128735 of the Health and Safety Code. This is not to be construed to require the public disclosure of individual plan specific rates or revenues.

3) Requires audited financial reports produced, disclosed, or otherwise made by physician organizations that are part of a fully integrated delivery system to be publicly disclosed by OHCA using a process equivalent to the process for public disclosure of health facility information submitted pursuant to subdivisions (a) to (e) of Section 128735 of the Health and Safety Code.

4) Specifies that the information in 2) and 3), above, includes balance sheets, statements of changes in equity, income statements, statements of cash flows, revenues by payer, expenses by natural classification, cost allocation statistics and calculations, and labor hours and hourly rates.

5) Deletes a provision of existing law that prohibits all information and documents related to financial information obtained by OHCA from being disclosed under the CPRA or any similar local law requiring the disclosure of public records.

6) Makes various findings and declarations of the Legislature, including:
   a) more than 25 percent of the money spent on health care services in California is spent on physician and clinical services. From 1980 through 2019, spending in California on physician and clinical services increased by an average of more than 7 percent each year from $7,200,000,000 in 1980 to more than $101,000,000,000 in 2019;
   b) there is insufficient data available publicly to show how much of that money went to provide services to patients and how much was held as profit by physician organizations or distributed to shareholders and investors; and
   c) it is in the interest of the state and of purchasers and consumers of health care services to have a more complete understanding of the financial standing of physician organizations in California. That information would advance efforts to reduce unnecessary health care spending, thereby making high-quality health care more affordable.

COMMENTS

1. Stated need for the bill

The author writes:

> Rising health care costs are a major burden on consumers, businesses, and the state budget. Over the past twenty years, the cost of medical care has grown much faster than non-medical inflation, and rising deductibles and cost sharing mean that burden increasingly falls on California's families. An important piece in understanding how to reduce the growth in health care costs is understanding the finances of health care providers. Put simply, we cannot manage what we cannot measure.
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> This bill will provide greater transparency into health care spending by allowing public disclosure of medical group financial data that is already collected by the state. This bill creates consistency between data release practices for medical groups and the public disclosure practices already used for equivalent hospital, skilled nursing facilities, clinics, and health plan financial data.

2. Background

a. Health care affordability has reached a crisis point - OHCA

OHCA was just established last year through the California Health Care Quality and Affordability Act (Act) (SB 184 (Committee on Budget and Fiscal Review, Ch. 47, Stats. 2022)), which was enacted in recognition that health care affordability has reached a crisis point. OHCA's website notes that:

> Health care spending in California reached $10,299 per capita and $405 billion overall in 2020, up 30% from 2015. Californians with job-based coverage are facing higher out-of-pocket costs, with the share of workers with a large deductible ($1,000 or more) increasing from 6% in 2006 to 54% in 2020. For the third consecutive year, the 2022 CHCF California Health Policy Survey found that half of Californians (49%) – and fully two-thirds of those with lower incomes (under 200% of the federal policy level) – reported skipping or delaying at least one kind of health care due to cost in the past 12 months. Among those who reported skipping or delaying care due to cost, about half reported that their conditions worsened as a result.[2]

The Act emphasized that it is in the public interest that all Californians receive health care that is accessible, affordable, equitable, high-quality, and universal, and tasked OHCA with three primary responsibilities: managing spending targets, monitoring

[2] Office of Health Care Affordability, *Overview*, available at https://hcai.ca.gov/ohca/.

system performance, and assessing market consolidation. In order to perform these duties, OHCA "will collect, analyze, and publicly report data on total health care expenditures, and enforce spending targets set by a new Health Care Affordability Board. To ensure a balanced approach to slow spending growth, OHCA will monitor system performance by measuring quality, equity, adoption of alternative payment models, investment in primary care and behavioral health, and workforce stability. Through cost and market impact reviews, OHCA will analyze transactions that are likely to have a significant impact on market competition, the state's ability to meet targets, or affordability for consumers and purchasers. Based on results of the review, OHCA will then coordinate with other state agencies to address consolidation as appropriate."[3]

b. RBOs

Under existing law, RBOs are required to submit quarterly and annual financial reports to DMHC, which are based upon the RBO's annual audited financial statement prepared by an independent certified public accountant in accordance with generally accepted accounting principles. The DMHC will make the following information available on its website within 120 days following each reporting period due date:

- a list of all RBOs that have submitted substantially complete financial survey forms, if required, and whether the RBO's submission reflects that the organization has met or not met each of the Grading Criteria;
- a list of all "non-compliant" organizations that failed to substantially comply with the reporting obligations, including submission of the financial survey reports; and
- comparative, aggregated data on all RBOs, and information that enables consumers to assess an RBO's relative financial viability.[4]

The Senate Health Committee provides a detailed description of RBOs in the health care market place in this state:

> An RBO contracts with health plans on a capitated payment basis, meaning it is paid on a per member per month basis. The RBO accepts risk on professional (physician services) and pays claims to providers it contracts with for those services. Generally speaking, accepting risk means that if more expenses occur above the plan contract amount the RBO losses money. If less expenses occur the RBO saves money. The objective is for the RBO to manage services in a manner that provides better quality at lower cost. Since the RBO accepts risk, it must register with DMHC and meet financial solvency standards. According to a 2022 California Health Care Foundation report there were 201 RBO physician organizations registered in 2020.

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[3] *Ibid.*

[4] DMHC, *Risk Bearing Organizations (RBO) – Financial Report Results*, https://dmhc.ca.gov/LicensingReporting/RiskBearingOrganizations/RBO%E2%80%93FinancialReportResults.aspx.

RBOs had 8.8 million enrollees as of 9/30/2021, 2.7 million in the commercial HMO market, 4.9 million in Medi-Cal managed care, and 1.2 million in Medicare. There is much less known about other physician practices and organizations. These physician organizations may accept capitation payments for services they provide, but they do not pay claims to other contracting or subcontracting providers. These physician organizations may also be paid on a fee-for-service basis, or both fee-for-service and capitation.[5]

Existing law makes DMHC responsible for conducting routine financial examinations of each health plan and issuing a public report for each plan a minimum of once every five years. In addition to routine examinations, DMHC conducts orientation examinations one year after licensing a new health plan and conducts non-routine financial examinations of health plans as may be needed. Financial examinations are conducted of all licensed health plans including full-service and all specialty health plans. The purpose of the financial examinations is to evaluate and report on regulatory compliance with KKA. Each financial examination discusses plan performance in the areas of health plan fiscal and administrative functions. Final (public) reports that have been issued since July 1, 2001 are available on the DMHC website listed under the name of each health plan.

c. *Existing reporting requirements for hospitals, nursing homes and other long-term care facilities, and primary care clinics*

HCAI publically provides data collected on licensed acute care hospitals, long-term care facilities, such as licensed skilled nursing, intermediate care, and congregate living health facilities, and licensed primary care clinics. (Health & Saf. Code § 128735.) The information disclosed does not provide specific identifying information about employees, physicians, or patients. The Hospital Annual Disclosure Report includes general hospital information, type of ownership, medical staff specialties, hospital services inventory, number of beds, utilization data by payer, balance sheets, statements of changes in equity, income statements, statements of cash flows, revenues by payer, expenses by natural classification, cost allocation statistics and calculations, and labor hours and hourly rates.[6] Long-term care facility data collected by HCAI and publically disclosed includes general facility information, patient days and revenue by payer, balance sheet, statement of changes in equity, income statement, statement of cash flows, expenses, and labor detail.[7] Primacy care clinic data that is publically disclosed includes basic clinic identification information, such as community services, clinic staffing data, and patient and staff language data; financial information, including gross revenue, itemized write-offs by program, an income statement, and selected

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[5] Sen. Health Comm. Analysis AB 616 (2023-24 Reg. Sess.) as amended Mar. 28, 2023, at p. 5.
[6] HCAI, *Hospital Financials*, available at https://hcai.ca.gov/data-and-reports/cost-transparency/hospital-financials/#hospital-annual-disclosure-report.
[7] HCAI, *Long-Term Care Facility Financial Data*, available at https://hcai.ca.gov/data-and-reports/cost-transparency/long-term-care-facility-financial-data/#available-data-products.

capital project items; and information on encounters by service, principal diagnosis, and procedure codes.[8] Additional data publically provided includes information on the number of clinics by type, the number of patients broken down by race, ethnicity, gender and age, the number of encounters by payer source, and revenues by payer source, including the average revenue per encounter. This data is presented in a variety of formats including: individual reports: an open data portal where facilities are listed from top to bottom, and data fields span across columns; a pre-selected set of data representing a wide range of commonly used data items; and pivot trends and profiles.

3. This bill seeks to require public disclosure of certain financial information collected by OHCA and financial and other records of RBOs made available to DMHC

   a. *Existing law limits public disclosure*

The statutes that authorize OHCA to collect audited financial reports from providers and any physician organizations that are part of a fully integrated delivery system provides that the audited financial reports and comprehensive financial statements are to be kept confidential, and that the confidential information and documents used only as necessary for the function of the office. Additionally, the statute expressly provides that the reports are not required to be disclosed under the CPRA or any similar local law requiring disclosure of public records. (Health & Saf. Code § 127501.4(i)(3).) This bill removes this provision, and instead specifies that audited financial reports or comprehensive financial statements produced, disclosed, or otherwise made available to OHCA by physician organizations comprised of 50 or more physicians are to be made open to public disclosure. Amendments taken in the Senate Health Committee specify that this language is not to be construed to require the public disclosure of individual plan specific rates or revenues. Additionally, the bill provides that audited financial reports produced, disclosed, or otherwise made available to OHCA physician organizations that are part of a fully integrated delivery system are to be publicly disclosed by OHCA. The bill requires public disclosure by OHCA to be equivalent to the process for public disclosure of health facility information submitted pursuant to subdivisions (a) to (e), inclusive, of Section 128735.

The statute that requires RBOs to provide financial and other records to the DMHC requires the Director of DMHC to adopt regulations that, among other things, provides for the confidentiality of financial and other records to be produced, disclosed, or otherwise made available, unless as otherwise determined by the Director. (Health & Saf. Code § 1375.4(b)(7).) This bill, notwithstanding any other law, requires financial and other records of risk-bearing organizations to be produced, disclosed, or otherwise made available to DMHC to be open to public disclosure using a process equivalent to the process for disclosing health care service plan financial and administrative

[8] HCAI, *Primary Care Clinic Annual Utilization Data*, available at https://data.chhs.ca.gov/dataset/primary-care-clinic-annual-utilization-data.

information described in Section 1384 of the Health and Safety Code. Amendments taken in Senate Health Committee specify that this language is not to be construed to require the public disclosure of individual plan specific rates or revenues.

b. Proponents of the bill's arguments for the need of public disclosure

The proponents of the bill argue that while other large parts of the health care industry are subject to state-mandated transparency (e.g. hospitals, long-term care facilities, and primary care clinics, and health care service plans) of their financial records, financial data about medical groups collected by the state is largely exempt from public disclosure. They point to a March 2022 report from the California Health Care Foundation (CHCF), which raised concerns about the "gaps in information" in the structure and finances of medical groups:

> Existing sources create an incomplete picture of California's complex and rapidly changing physician landscape, without systematic capture and reporting on structure, affiliation, ownership, and payment arrangements. Significant gaps in information suggest that it may be worth considering measures to increase availability of data to support policymaking, practice, and research that can enable improvement in affordability and health system performance.[9]

Supporters of the bill point to increasing ongoing provider consolidation leading to large physician organizations gaining even more market power in the health care industry, and believe that it is appropriate to bring a similar level of public scrutiny to physician organizations as already exists for other entities in the health care market.

SEIU, sponsor of the bill, notes that on several states, certain medical groups, physician organizations, and facilities owned by physician organizations are required to report public financial data:

- Massachusetts: Medical groups affiliated with health systems report public financial data as part of the state's cost containment efforts.
- West Virginia: Ambulatory health facilities and ambulatory surgery centers submit audited financial statements, which are made public on the state's website.
- Washington: Health systems must submit public financial statements for their affiliated physician groups, urgent care clinics, and other subsidiaries.
- Alaska: Medical groups and other physician organizations must post the prices for their most common procedures on their website. The prices are also posted by the state Department of Public Health.

[9] Jill Yegian, PhD and Marta Green, *California's Physician Practice Landscape: A Rapidly Changing Market with Limited Data*, CHCF at p. 23, available at https://www.chcf.org/wp-content/uploads/2022/02/CAPhysicianPracticeLandscapeRapidlyChanging.pdf.

c. Opponents concerns with the bill

Opponents of the bill include associations representing various providers and physician organizations (such as Kaiser Permanente). Many of the opposition state that this bill reverses an agreement that was reached last year when OHCA was established – that the reports provided to OHCA be kept confidential and disclosed to the public. They note that OHCA has not even issued implementing regulations, yet changes are already being sought to its implementing statute. Additionally, the opposition believes that the information to be disclosed does not provide valuable insight to the health care delivery system and raises privacy concerns. Some opponents raise concerns regarding antitrust issues and that the bill will hinder their ability to recruit providers and employees, especially in rural and low-income communities.

4. <u>Statements in support</u>

Service Employee International Union California, sponsor of the bill, writes in support stating:

> Rising health care costs are a substantial burden on Californians, businesses that provide health insurance to their employees, and the state budget. To combat this problem, California is taking many steps to ensure that health care spending is efficient and effective, including the recent creation of the Office of Health Care Affordability and requirements that many entities within the health care sector regularly report financial information to the state.
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> As health care increasingly moves to outpatient settings operated by physician organizations, and as ongoing provider consolidation increases the market power of large physician organizations, it is appropriate to bring the same level of public scrutiny to physician organizations that already exists for other types of providers and health plans.
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> The Medical Group Transparency Act would remove the existing Public Records Act exemptions for financial data that physician organizations are already required to report to DMHC and HCAI, thereby creating a pathway for purchasers, researchers, policymakers, and other advocates to access the information.
>
> The result would be that medical groups would be subject to similar public transparency that currently exists for financial data reported by hospitals, skilled nursing facilities, clinics, and health plans. […]
>
> More than 25 percent of the money spent on health care services in California is included in the category "physician and clinical services" – more than $100 billion in 2020. However, for the medical groups and other physician organizations that make up the bulk of this category, there is very little publicly available information to

> show how much of that money is going to health care services and how much is kept as profit, disbursed to shareholders, or used for other nonclinical purposes. A March 2022 report from the California Health Care Foundation raised concerns about the "[s]ignificant gaps in information" created by the incomplete information publicly available about California's physician landscape. (footnotes omitted)

5. Statements in opposition

Kaiser Permanente writes in opposition stating:

> The public release of this highly sensitive information would have many unintended consequences. Mandating disclosure of competitively sensitive information, particularly in the health care sector, is likely to have an inflationary impact and raise health care costs. Health care is a highly competitive industry – disclosure of the compensation information and hiring strategies that that these reports contain, for example, could encourage employers to compete by raising compensation.
>
> Kaiser Permanente's concern last year was that the information in financial statements is not relevant to the work of OHCA, will not improve understanding of health care cost drivers and will not help in setting cost targets. But we agreed to a compromise in last year's bill to submit the information to OHCA if the information is kept confidential and only used for the work of the Office. This language, and other important amendments to the bill, ultimately removed our opposition.
>
> Kaiser Permanente, alongside many stakeholders, moved forward with this compromise last year in AB 1130 and ultimately SB 184, the budget trailer bill that implemented OHCA. AB 616 is troubling in that it reverses the outcome of those good faith negotiations. We would respectfully request that compromise be honored.

SUPPORT

Service Employees International Union California (sponsor)
Asian American Drug Abuse Program, Inn.
California Labor Federation, AFL-CIO
California Nurses Association
California Rural Legal Assistance Foundation, Inc.
California School Employees Association
California State Retirees
California Teachers Association
Disability Rights Legal Center
Health Access California
Leukemia & Lymphoma Society
National Health Law Program

National Nurses United
National Union of Healthcare Workers
Public Health Advocates
Public Law Center
Purchaser Business Group on Health
San Diego Electrical Health & Welfare Trust
Western Center on Law & Poverty

OPPOSITION

America's Physician Groups
California Ambulatory Surgery Association
California Medical Association
California Orthopedic Association
California Society of Anesthesiologists
California State Association of Psychiatrists
California Health+Advocates
Kaiser Permanente
MemorialCare
San Francisco Marin Medical Society

RELATED LEGISLATION

Pending Legislation: None known.

Prior Legislation:

SB 184 (Committee on Budget and Fiscal Review, Ch. 47, Stats. 2022), among many other provisions, created OHCA within HCAI to collect audited financial reports from providers and any physician organizations that are part of a fully integrated delivery system, except as specified, and made those documents not disclosable under the CPRA.

AB 1130 (Wood, 2022) was substantially similar to SB 184. AB 1130 was never set for a hearing in the Senate as the majority of its provisions were amended in to SB 184.

SB 261 (Speier, 2003) would have required certain financial information filed with the DMHC by RBOs to be publically disclosed, and would have required annual registration of RBOs. SB 261 was vetoed by then Governor Davis, stating "the Department currently is in the process of regulations implementing SB 260 (Ch. 529, Stats. 1999), the original bill that this measure is designed to amend. I believe the issues raised in this measure can be addressed during the regulatory process in a way that balances the integrity of the health care marketplace against public access to important financial data."

AB 1213 (Vargas, 2003) would have allowed public release of RBO financial data for RBOs with at least 10,000 covered lives. AB 1213 was not set for a hearing in the Senate Insurance Committee.

AB 684 (Kehoe, 2002) would have allowed the director of DMHC to make public all confidential financial information of a RBO. AB 684 was not set for a hearing in in the Senate Insurance Committee.

SB 260 (Speier, Ch. 529, Stats. 1999) required RBOs to register with DMHC and submit quarterly financial statements, and directed DMHC to establish a rating system for the RBOs based on data from the statements submitted.

PRIOR VOTES

Senate Health Committee (Ayes 9, Noes 1)
Assembly Floor (Ayes 53, Noes 17)
Assembly Appropriations Committee (Ayes 11, Noes 4)
Assembly Health Committee (Ayes 10, Noes 4)

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