San Diego Regional Chamber

Policy Brief

May 2018

AB 3087 (KALRA): CALIFORNIA HEALTH CARE COST, QUALITY & EQUITY COMMISSION

POSITION: The Chamber's Public Policy Sub-Committee Health voted to OPPOSE AB 3087 on April 11, 2018. The Chamber's Public Policy Committee voted to OPPOSE AB 3087 on May 7, 2018.

RATIONALE: Arbitrary price caps set by a third-party commission will not achieve the bill's goal of addressing the rising cost of healthcare.

STATUS: The bill was introduced on February 16, 2018 by Assemblymember Ash Kalra. It was referred to the Assembly Committee on Health where it passed on April 24th 11-4-0. It has been amended and is awaiting referral out of committee.

SUMMARY

AB 3087 creates an 11 person commission, titled the Health Care Cost, Quality & Equity Commission (Commission) to control in-state health care costs, primarily by setting the amounts accepted as payments by health plans, hospitals, physicians, physician groups and other health care providers. Commissioners will all be required to be residents of California and broken down as follows: three Governor appointments; three Senate Rules Committee appointments; three Assembly Speaker appointments; the Secretary of Health & Human Services; and a CalPERS representative. The bill further dictates the terms and recommends consideration of the expertise of members. AB 3087 bars commissioners from being employed in the healthcare industry (with the exception of including a singular health care provider on the commission).

The Commission is then directed to convene a 15 person advisory committee comprised of health care stakeholders and providers, each serving a term of at least one year, and meet at least once every quarter.

The Commission on or before July 1, 2019, to adopt regulations that will establish the Purchaser Participation Program, which will distribute advocacy and witness fees to those persons or organizations that participate in work with the Commission.

By July 1, 2019, the Commission will be expected to establish base amounts that health care entities accept as payments in full for health care services, based on existing Medicare rates. The rates may not be lower than 100% of Medicare rates.

INDUSTRIES IMPACTED

This bill would significantly impact any business affiliated with the healthcare industry as prices will be set by an independent commission, removed at least to some degree, from market forces. Prices in the future will be difficult to predict, which will challenge long-term planning and possibly impact workforce numbers as salaries will necessarily be tied to rates set by the Commission.

SUPPORTERS

California Labor Federation (sponsor)
Health Access California (cosponsor)
SEIU California (cosponsor)
UNITE HERE International Union (cosponsor)
CA Conference of Machinist

OPPONENTS

Alliance of Catholic Health Care
California Academy of Family Physicians
California Ambulance Association
California Association of Health Plans
California Chamber of Commerce

CA Teachers Association
California Teamsters
Western Center on Law & Poverty
And others

California Dental Association
Scripps Health
Sharp Health
And others

ARGUMENTS IN FAVOR

Health Access California, a cosponsor of the bill, says "this bill helps rein in rising health care costs and protects consumer's pocketbooks. While preventing inflated and unjustified rates, providers are guaranteed rates higher than Medicare."

ARGUMENTS IN OPPOSITION

The California Hospital Association opposes the bill, saying that hospitals could lose an estimated $18 billion annually in revenue, which will lead to cuts in service and hospital operations, which will disproportionately impact areas already struggling with health access.

MORE INFORMATION

The costs of healthcare, and the inability thus far to identify better ways of reining in prices have resulted in a variety of sweeping measures at the state. However, for all the arguments around capping or restraining the cost of care, California serves one of the largest Medicare populations, referred to as Medi-Cal within the state (covering 14 million individuals), which reimburses providers at a lower rate than private plans. As a result, there is worthy concern that tying rates for the foreseeable future to the already lacking Medi-Cal rates is a troublesome idea for providers. Most providers argue that the only way for them to accept Medi-Cal patients and their low reimbursement rates is to balance those patients with privately insured individuals. Under such a proposal as AB 3087, such practices would be restrained.