LEGISLATIVE UPDATE

Alliance of Catholic Health Care

Week of April 22, 2024

State Issues	
Key Legislative Deadline	Today (Friday) is the last day for fiscal bills to pass out of the policy committees in the house of origin. A few bills of note: **SB 1432 (Caballero)** would grant hospitals an extension to reach the 2030 seismic standards. This perennial issue continues to be contentious between hospital providers and labor unions. The California Hospital Association, which is sponsoring the measure, has accepted soon-to-be-in-print amendments that reflect a 3-year extension with the option for HCAI to provide another 5 years, if certain criteria are met. The members of the Committee expressed concerns that some hospitals may be granted the exemption when they don't need it, but Chair Roth encouraged all to vote in support of the bill to keep the conversation going. **AB 2200 (Kalra),** which would create a single payer health care system, passed the Assembly Health Committee with the advocates and opponents giving basically the same speech the last few times this bill has been introduced. This year, though, the Committee included Assembly Member Schiavo (D-Chatsworth), who was a single payer advocate before joining the legislature and added a great deal of detailed supportive comments from the dais. Speaker Rivas has acknowledged that the state budget is still in deficit, and will be for at least several years, and cannot absorb the $400 to $500 billion price tag this proposal needs for it to be implemented. Common wisdom is that the bill cannot make it through the legislative process this year. However, the big question is who is going to take the political hit to stop the bill. Its next stop is the Assembly Appropriations Committee, which seems a logical place to stop the bill for cost reasons and protect the full Assembly from having to vote on it. But that would mean a political hit for Chair Buffy Wicks who is a vocal supporter of single payer health care. **AB 3275 (Soria, Rivas)** is a gut and amend bill authored by the new Chair of the Select Committee on Distressed Hospitals and the Assembly Speaker. The bill would require health plans, including Medi-Cal, to reimburse certain hospital providers (small, rural and those that qualify for the Distressed Hospital Loan Program) to be paid claims within specific timeframes. Health plans are delaying prompt payment to many hospitals and these delays are severely impacting their financial viability, including those that serve vulnerable Medicare and Medi-Cal patients. The current payment timeframes are not sustainable for these hospitals because of their payor mix. A number of stakeholders will be seeking to expand the definition of which hospitals the bill applies to as it moves through the legislative process. **AB 2180 (Weber)** would ban co-pay accumulators. Specifically, the bill requires health plans or pharmacy benefit managers (PBMs) to apply any amounts paid by the patient or a patient assistance program towards the enrollee's cost sharing requirement for those who have a chronic disease or terminal illness. *(more)*

Key Legislative Deadline *(continued)*	Co-pay accumulators are used by health insurers and PBMs to prevent copay assistance given to patients from counting towards their deductible and maximum out of pocket spending, which greatly reduces the cost to payers while placing an extreme financial burden on patients. Supported by patient advocate groups and the biopharmaceutical companies, and opposed by insurers and PBMs, the bill made it out of Committee on a unanimous vote.
0ffice of Health Care Affordability	After months of discussion and an exceptionally chaotic meeting, the Office of Health Care Affordability Board adopted health care expenditure targets (caps) for California's health care delivery system. The board finalized a five-year health care spending growth target that will be phased in as follows: ▪ 3.5% non-enforceable target in 2025 ▪ 3.5% enforceable target in 2026 ▪ 3.2% enforceable target in 2027 ▪ 3.2% enforceable target in 2028 ▪ 3.0% enforceable target in 2029 There is concern from many providers that the Board did not adequately consider the impact on access to care in creating these exceptionally low targets and did not consider costs outside of the control of health care providers, such as legislatively mandated wage increases, costs affiliated with health care innovations and technologies, inflation, or the increased costs expected to provide care for an aging population. The Board is continuing its work on setting workforce stabilization standards and hospital-specific spending targets.

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