HCAi Department of Health Care Access and Information
2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833
hcai.ca.gov

Health Care Affordability Board
April 24, 2024
Public Comment

The following table reflects written public comments that were sent to the Office of Health Care Affordability email inbox.

Date	Name	Written Comment
5/17/2024	Health Access California	See Attachment #1.
5/20/2024	California Hospital Association	See Attachment #2.

HEALTH ACCESS CALIFORNIA

May 14, 2024

Mark Ghaly, M.D.,
Health Care Affordability Board Chair

Elizabeth Landsberg, Director,
Department of Health Care Access and Information

Vishaal Pegany, Deputy Director
Office of Health Care Affordability

2020 W. El Camino Ave,
Sacramento, CA 95814

Re: May 22, 2024, Health Care Affordability Board Meeting

Dear Dr. Ghaly, Ms. Landsberg and Mr. Pegany,

Health Access California, the statewide health care consumer advocacy coalition committed to quality, affordable health care for all Californians writes to thank the Board and staff of the Office of Health Care Affordability for its work to set California's first spending growth target decision. On behalf of the 80% of California consumers who make less than $146,000 in annual income, we applaud this decision[1]. For these Californians, health care costs have become unaffordable, denying them access to care, and resulting in worse outcomes and disparities. This decision, along with those pending in coming months on primary care, alternative payment models, workforce stability and market reviews will guide the work of the Office and health care over the years to come.

A well-functioning health system is one with costs that are affordable to consumers and other purchasers as well as one that prioritizes primary care, provides better access to behavioral health care, takes advantage of alternative payment models to promote the triple aim of lower costs, improved outcomes and greater health equity while not destabilizing the health care workforce. The Office of Health Care Affordability is a critical strategy to move California forward toward all of these goals. The new cost growth base target of 3% moves us closer to this vision.

In this letter, we also offer comments on the proposed primary care benchmarks, alternative payment model standard and workforce stability standards as well as the forthcoming work on hospital spending.

Spending Growth Target Adoption

[1] ITEP https://itep.org/whopays/california-who-pays-7th-edition/

While we, along with other consumer, labor, and other purchaser organizations, supported the staff recommendation for a 3% growth target for the five years from 2025 to 2029, we appreciate the compromise motion that was adopted by the Board to set a base target of 3% but with a phase-in from 3.5% to 3% over the five years. We also support the proposal to monitor performance by line of business (Medicare, Medi-Cal, commercial) as provided in the statute and justified by sound policy reasons. We do so on behalf of the 80% of California households that make less than $146,000 in annual income[2]. These are households for whom staying at the Ritz-Carleton (at $979 a night) is incomprehensible and for whom the median share of family premium and the median deductible of over $10,400[3] are not affordable.

The epidemic of lack of affordability of health care, made worse by the regressivity of employer-sponsored insurance, today denies Californians access to necessary care, imperils the quality of care, and worsens health equity. The vote to set a meaningful spending growth target begins the long journey of making the investments and innovations that can bend the cost curve and move California toward an improved health system. We look forward to working with those in the health care system that recognize the importance of changing course to achieve greater affordability for consumers. Virtually every penny of health care spending comes out of the pockets of consumers, directly or indirectly, as taxpayers, as workers, and as patients. Those who fail to recognize this and who fail to recognize that overall health status is worsened by the lack of affordability deny the fundamentals of a well-functioning health system.

The Health Care Affordability Board, supported by the work of the Office of Health Care Affordability, chose a goal for health care cost growth that is credible to Californians based on the premise that health care costs should not grow faster than median income has historically. While some may debate whether the goal is modest or ambitious, the work looking forward to make that goal a reality.

Primary Care Benchmarks

The Goal: Coordinated Primary Care Anchoring the Delivery of Care

Well-functioning health systems around the globe prioritize primary care that anchors care delivery and is well coordinated with other medically necessary care. Volumes of research summarized by the National Academies of Sciences, Engineering and Medicine[4] as well as numerous other studies[5] find that systems with greater reliance on primary care have lower costs and better outcomes, both in terms of the quality of care, satisfaction with care, and if done well, reduced disparities. The crafters of the OHCA law were well aware of this research and included the requirement for primary care benchmarks in the belief that stronger primary care delivery was central to the California triple

[2] ITEP https://itep.org/whopays/california-who-pays-7th-edition/
[3] https://laborcenter.berkeley.edu/measuring-consumer-affordability/
[4] National Academies of Sciences, Engineering, and Medicine (NASEM). Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. 2021.
[5] Jabbarpour Y., Petterson S., Jetty A., Byun H. The Health of US Primary Care: A Baseline Scorecard Tracking Support for High-Quality Primary Care, 2023. California Health Care Foundation; Investing in Primary Care: Why It Matters for Californians with Commercial Coverage. April 2022; Patient-Centered Primary Care Collaborative and Robert Graham Center. Investing in Primary Care: A State-Level Analysis. July 2019; California Health Care Foundation. Investing in Primary Care: Lessons from State-Based Efforts. April 2022. 24

1127 11th Street | Suite 925 | Sacramento, CA 95814

aim of lower costs, better outcomes and improved health equity. Our comments fit within this vision of the role of primary care.

Retail Clinics, Urgent Care Centers

The reliance of California consumers on retail clinics and urgent care centers for primary care is a symptom of the current failed system. Use of such stop-gap care is too often the hallmark of uncoordinated care. The lack of timely access to adequate primary care that is coordinated with other necessary care is precisely what these benchmarks are intended to correct or at least to move California toward. Shortages of primary care doctors and lack of adequate plan networks force consumers to seek uncoordinated care from retail clinics and urgent care clinics, not because that is good care or the preference of consumers, but because of the lack of timely and adequate access to primary care. For these reasons, Health Access opposed the inclusion of retail clinics and urgent care centers in the primary care benchmarks. We also recognize that current claims processes may make it challenging to distinguish primary care visits from retail clinic and urgent care center use. These are practical problems to be solved, just as estimating the proportion of primary care spending in global capitation is a problem to be solved rather than a reason not to prioritize primary care.

Obstetricians-Gynecologists?

One of the policy questions raised by various commenters was whether obstetricians-gynecologists should count as primary care providers for purposes of the benchmarks. Some commenters point to the Knox-Keene Act provisions on this point.

A review of the actual language of the law is helpful:

> Health and Safety Code 1367.69.
> (a) On or after January 1, 1995, every health care service plan contract that provides hospital, medical, or surgical coverage, that is issued, amended, delivered, or renewed in this state, shall include obstetrician-gynecologists as eligible primary care physicians, provided they meet the plan's eligibility criteria for all specialists seeking primary care physician status.
> (b) For purposes of this section, the term "primary care physician" means a physician, as defined in Section 14254 of the Welfare and Institutions Code, who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, and for initiating referral for specialist care. This means ***providing care for the majority of health care problems, including, but not limited to, preventive services, acute and chronic conditions, and psychosocial issues.*** (Emphasis added)

This standard is consistent with the vision underlying the proposed primary care benchmark. It is our understanding that not many obstetricians-gynecologists choose to meet this standard. Perhaps if primary care were reimbursed at the same level as specialty care, more OB-GYNs would choose to serve as primary care physicians. For the moment, few do.

Also, one commenter noted that some health plan directories of contracted providers list OB-GYNs as primary care providers. Health Access as the sponsor of the existing state law on provider directories and pending legislation, AB 236 (Holden) updating that law, notes that some plan

1127 11th Street | Suite 925 | Sacramento, CA 95814

directories of contracted providers are as much as 80% inaccurate and for most of these directories, a quarter to a third of the entries are in error. Given this abysmal record of inaccuracy, inclusion of information in a provider directory seems a thin reed on which to base policy.

Alternative Payment Model Standards

Health Access supported inclusion of the alternative payment model standard development as part of the OHCA enabling statute and we have participated in the Investment and Payment Workgroup as part of our commitment to the effort to move toward more coordinated care that prioritizes primary care and behavioral health. We offer comments on various elements of the proposed standards.

Addressing Affordability through Benefit Design

The standard benefit designs adopted by Covered California, which have been developed collaboratively among consumer advocates, health plans and the state agency are proof of concept for the APM standard encouraging affordability of benefit designs. Covered California in its benefit design work has prioritized primary care with benefit designs that offering lower cost sharing for primary care and generic drugs and developing a standardized four-tier formulary with a cap on drug cost sharing that limits cost exposure for the most expensive drugs. Covered California was able to do this despite being hampered by the lack of affordability of the basic silver plan which only covers 70% of the cost of care for an average population, an actuarial value that provides far less affordability than typical employer coverage though far greater affordability than the pre-ACA individual market. Recent action in the federal Inflation Reduction Act as well as state level action led by Governor Newsom and Assemblymember Jim Wood have significantly improved affordability of premiums and cost-sharing. With or without the improved help, Covered California benefit designs provide a template for how to prioritize primary care and lower cost drugs.

Income as well as RELD-SOGI

Health Access supports the collection of demographic data on race, ethnicity, language, disability, sexual orientation, and gender identity (RELD-SOGI) as foundational to a well-functioning health system. Innumerable studies document the relevance of each of these factors in addressing health disparities across many domains of the health care delivery system.

Health Access asks that income be added. While payers may lack information on income, employers are well aware of what workers are paid. For those in the bottom 90% of the income scale, ages 18-65, earned income for a worker is strongly though not perfectly correlated with family income. Those in the top 10% of the income scale may have unearned income from investments but few in the bottom 90% do. Income is strongly correlated with social determinants of health and predictive of health disparities. Being poor is bad for your health. For those California consumers with individual coverage, Covered California enrollment is a source of information on income. For those with employer coverage, earned income from a single employer is a solid though not perfect source of information. Information about income would help to prioritize equity in our health system.

PPO vs HMO

1127 11th Street | Suite 925 | Sacramento, CA 95814

Most HMO coverage in California already relies on alternative payment models. Conversely, most PPO coverage does not. For both APM standards and primary care benchmark, part of the puzzle is how to move PPO coverage toward greater reliance on primary care and alternative payment models. Consumers who chose a PPO are not rejecting primary care or coordination of care: they are seeking the appearance of broader choice of providers. Increasing access to, and use of, primary care and more coordinated care should be possible within a PPO model.

Direct Contracting: Oppose

Health Access opposes direct contracting in which health systems or physician organizations contract directly with purchasers such as self-insured employer plans to accept risk for care because these arrangements undo the consumer protections in California law. Permitting such arrangements would require a change in state law which Health Access would oppose.

Consumer protections in California law include, but are not limited to, financial solvency, timely access to care, network adequacy, language access and many more. Most direct contracting arrangements involve third party administrators which are also licensed health care service plans. It is well within the capacity of those carriers to offer fully licensed coverage, even to very large purchasers. Such carriers, many of them domiciled elsewhere, have the capacity to comply with state law but chose not to do so. From a consumer perspective, state law is not a barrier to direct contracting that can be set aside: instead, it is a very important set of consumer protections, and we oppose any effort to undo or lessen those protections.

Workforce Stability Standards

The foundation of developing standards in any policy domain is transparency of information, which relies on requirements to collect data and make it public so that the Board, staff, policy makers and the public can determine whether the Office is achieving its statutory goal of assuring workforce stability while reducing cost growth and improving quality and equity. The proposed standards fail to meet this baseline by failing to require the collection of sufficient data to allow monitoring of the larger workforce impacts of changes in health care in response to the spending targets.

We know from the experience of Massachusetts, the state with the longest experience with a spending target, that workforce employment did not decline and that the Covid pandemic had workforce impacts similar to those in other states without spending targets. From this experience, we know it is possible to implement spending growth targets without damaging workforce stability. We also know that too many health care employers prioritize their bottom lines over delivering care in a manner that is effective and efficient. Stable workforces improve the quality of care and allow better care management. That is true whether it is doctors or nurses or any other health care occupation. Workforce stability is an important element of achieving the goal of reduced costs while strengthening quality and equity.

Health Access strongly supports the workforce stability standard that is intended to promote diversity in the workforce and address the population need for culturally and linguistically competent care.

1127 11th Street | Suite 925 | Sacramento, CA 95814

Summary
On behalf of the 80% of California families who live on less than $146,000 a year, Health Access again thanks the Board and staff for setting a target based on historical median income, resulting in a base target of 3%, phased in over the first five years.

We support moving forward toward a better functioning health care system, that moves toward alignment of prices across coverage sources with greater reliance on primary care, continuing move toward alternative payment models and the information necessary to evaluate workforce stability, centering cultural and linguistic competency.

Sincerely,

Beth Capell, Ph.D.
Policy Consultant

Anthony Wright
Executive Director

CC: Members, Health Care Affordability Board
Assemblymember Robert Rivas, Speaker of the Assembly
Senator Mike McGuire, Senate President Pro Tempore
Assemblymember Mia Bonta, Chair, Assembly Health Committee
Senator Richard D. Roth, Chair, Senate Health Committee

1127 11th Street | Suite 925 | Sacramento, CA 95814

California Hospital Association

May 20, 2024

Mark Ghaly, MD
Chair, Health Care Affordability Board
1215 O St.
Sacramento, CA 95814

Subject: **Comments on the April 2024 Health Care Affordability Meeting**
(Submitted via Email to Megan Brubaker)

Dear Dr. Ghaly:

Californians rely on hospitals for lifesaving care in their time of greatest need. California's hospitals recognize that accessible, affordable care is out of reach for too many patients and stand ready to work with the Office of Health Care Affordability (OHCA) and other stakeholders to transform our health care system into one that best serves patients. On behalf of more than 400 hospital and health system members, the California Hospital Association (CHA) appreciates the opportunity to comment on the April Health Care Affordability Board meeting.

Meaningful Evaluation of Health Care Spending Trends, Drivers, and the Target Is Needed Now

The Approved Spending Target Is Out of Line with Key Trends. After a year of deliberation, the OHCA board in April formally adopted California's first health care spending target. The approved methodology is generally consistent with OHCA's earlier proposal — it is based on median household income growth over the last 20 years — but includes an add-on factor for the first four years to incorporate a glide path. The target will start at 3.5% in 2025, move to 3.2% after two years, and further shrink to 3% in 2029.

The addition of a glide path was a step in the right direction. However, it remains unclear whether California's health care system will be able to sustain the level of care patients deserve and still achieve this strict constraint on health care spending growth. Ultimately, California's adopted spending target does not account for the demographic, economic, policy, and health care trends that will drive health care spending growth going forward. For example:

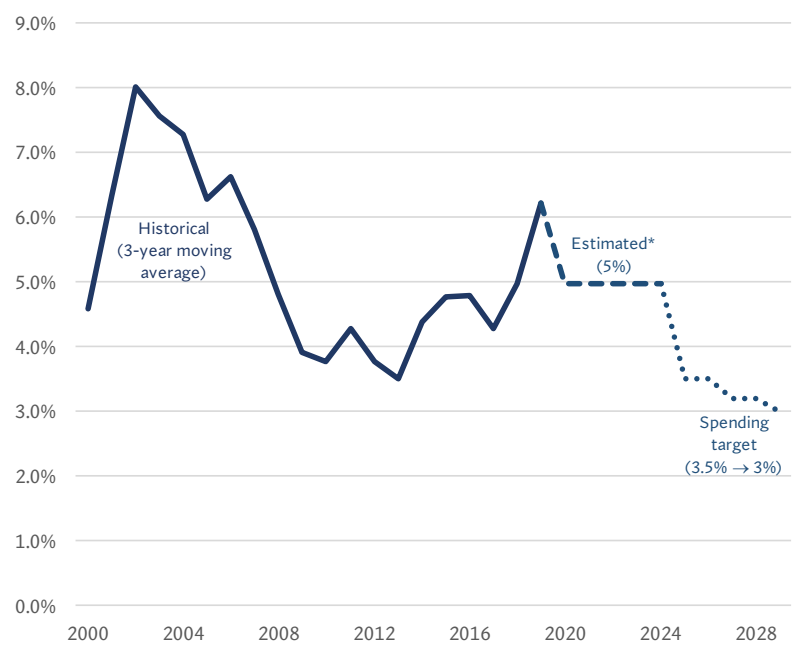
- Meeting a 3.5% spending target in year one would require a sudden 30% drop in the growth of health care spending, which cannot be achieved without serious negative consequences for patient care.
- As the following figure shows, 3.5% is the lowest rate of health care spending growth California experienced in the last 20 years — and it occurred more than a decade ago. Achieving a 3% target would require spending growth to be cut an additional 15%.

- These cuts in growth must occur in a high-inflation environment with annual price growth higher than 3%. When California last achieved sustained health care spending growth of less than 4%, economy-wide inflation was only 1.5% to 2%.

- Health care spending cannot keep pace with inflation unless utilization of services is flat or declining. But in California, population aging, growing prevalence of chronic disease, and escalating behavioral health needs mean that demand for health care will only grow in the coming years.

Approved Spending Target Mandates Health Care Spending Growth Far Below Historical Levels

Annual Growth in Per Capita Health Care Spending



*Growth for the years 2021 through 2024 are estimated because data on actual growth is not currently available from the National Health Expenditure accounts

- There are opportunities to improve the efficiency and effectiveness of health care delivery, including through the adoption of new technologies, better care coordination, greater alignment of financial incentives, and expanded preventive care. However, savings from these care transformations are uncertain, likely to arise slowly (while often necessitating upfront investment), and far below the levels necessary to meet the spending target.

- Workforce shortages, excessive pharmaceutical prices, and medical supply constraints — all factors outside of hospitals' control — caused hospital expenses to increase by well over 6% over the last few years. While some of these cost pressures have partially subsided, trends in the costs of these essential inputs remain out of line with OHCA's spending target. This discrepancy between revenue and cost growth is ultimately unsustainable and will force providers — especially those in vulnerable communities that are already experiencing financial challenges — to cut service lines or close entirely, eroding access to care.

Important Work to Evaluate the Sustainability of the Target Should Begin Now. Given the many factors that will undermine providers' ability to achieve a 3% to 3.5% spending target without negatively impacting care delivery, it is critical that OHCA thoughtfully and thoroughly analyze progress toward the target and the broader effects of that progress on the health care system. Only with this detailed, ongoing analysis will the OHCA board be able to evaluate the target's effectiveness in reaching OHCA's statutory objective of promoting affordability while maintaining access, quality, and equity. With that deeper understanding, the board would be able to meaningfully consider whether to modify the spending target or its methodology in future years.

This work should contain two general pieces of analysis:

- **A prospective analysis that forecasts the likely impacts of the adopted spending target on access, quality, equity, and workforce stability.** Such analysis has previously been requested from OHCA board members. To be supportive of the office's work, the analysis should:
    - Identify workforce changes health care entities would have to make to align their expenses with the spending target
    - Outline provider closures and service-line eliminations that are likely to result (particularly in rural and underserved areas)
    - Examine strategies payers might employ to constrain their expenses to meet the target, such as increasing denials of care, adding hoops to obtain new health care therapeutics, and adding cost sharing
    - Project, based on the aforementioned factors, the impacts to patients' access to care (from both geographic and timeliness perspectives)

  To date, these critical questions remain unanswered despite an abundance of academic literature and the available expertise of professional actuaries who consider these issues every day. Comparative approaches would be informative; the office should look closely at why other states are usually missing their (often higher) spending targets and why peer countries, like Sweden, the United Kingdom, and Canada experience health care spending growth that is twice as high as California's target despite more regulated health care systems.

- **Retroactive analysis that comprehensively monitors performance of California's health care system.** While the planned quality and equity measures and workforce stability standards will help in this regard, they do not provide all the necessary information. For example, they will likely not capture trends in appointment travel and wait times, whether patients are able to access new and effective therapeutics, and whether payers are putting up new barriers to care. This information will be critical in allowing the OHCA board to pivot where necessary to ensure access, quality, and equity are not being harmed in this process.

Establish a Formal Process for Reevaluating and Reconsidering the Spending Target. Setting the spending target was the most important and impactful decision the OHCA board will take this year. While the board has fulfilled this statutory mandate for the next five years, it retains a duty to continuously reevaluate and reconsider this important decision as additional information arises, including through the analyses described above and by considering more up-to-date economic and health care spending trends. Exactly how the OHCA board will do this is unclear, offering little assurance that this duty will be adequately performed. At an upcoming board meeting, the board should discuss and establish a public process and schedule for continuously reevaluating the spending target for each of the next five years.

Conclusion

OHCA must plan for the health care system Californians need and deserve. The state must address affordability challenges while meaningfully and measurably improving access to high-quality, equitable, and innovative care.

As work toward that multi-faceted goal progresses, California's hospitals are eager to help the OHCA board more fully understand the ever-changing health care landscape. We are grateful for the opportunity to comment and look forward to continued collaboration on this important work.

Sincerely,

Ben Johnson
Vice President, Policy

cc: Elizabeth Landsberg, Director, Department of Health Care Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability
Members of the Health Care Affordability Board:
David M. Carlisle, MD, PhD
Secretary Dr. Mark Ghaly
Dr. Sandra Hernández
Dr. Richard Kronick
Ian Lewis
Elizabeth Mitchell
Donald B. Moulds, Ph.D.
Dr. Richard Pan