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Health Care Affordability Board
April 25, 2023
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
4/25/23	Patrick Pine	I want to compliment the Board and staff and the presenters at today's meeting. Thank you. I am Patrick Pine, Administrator of the Robert F. Kennedy Farm Workers Medical Plan, the union benefit plan for the United Farm Workers. The Plan provides comprehensive medical benefits to farmworker employees and eligible dependents of agricultural employers with collective bargaining agreements with the UFW and employees and eligible dependents of organizations with an affiliation with the UFW. The majority of our funding comes from private employers. The Plan is always under pressure to keep its costs low both for the benefit of the farmworker families the Plan covers but also for the employers who provide most of the funding as well as the UFW itself. And we have been successful in keeping our costs down compared to other plans but often have to push very hard in negotiations with hospitals when it comes to our most expensive claims. We know that this office and the similar offices in other states like Oregon and Massachusetts that have been trying to put some limits on the cost of health care have will understandably look for ways to put some sort of index limiting the size of periodic increases in premiums. I am here to briefly urge you to look at the regional and localized differences in the costs of health care when looking at ways to control the growth of such costs rather than an across the board type of indexed approach. In our case a majority of the individuals we serve reside in Monterey and Santa Cruz counties. And we have endeavored to try to control the costs of the most expensive care which is nearly always delivered by hospitals. More than one recent independent study by reputable groups like Rand regarding hospital costs in California show that three major hospitals in Monterey County located in or near Salinas

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		are all billing at some of the highest rates in the state and the nation. Those hospitals include Community Hospital of the Monterey Peninsula, Natividad, and Salinas Valley Health which until recently was known as Salinas Valley Memorial. There are other hospitals – mostly in Northern California - who have comparatively high billing rates but there are other nearby hospitals with lower, more competitive billing rates. There are no nearby alternatives in the Salinas, Monterey, Carmel areas that the individuals we cover can easily go to. Without belaboring the arguments that hospital representatives have made and will make in defense of their billing rates and acknowledging that their representatives may contend that the plan I manage is uniquely underpaying, I can advise that there are other plan administrators who have significant numbers living in Monterey County who will attest that the hospital costs in the area are right at the top of the range of charges nationally. I encourage your office to take into consideration those geographic areas where the amounts being charged to commercial insurers is above the levels in other areas and markets. We have considered various factors in looking at the situation in Monterey County including the underlying cost of living, average wages, the degree of reliance on Medicare or Medi-Cal patients, the cost reports submitted by hospitals to CMS and quality of care indices, public reports of profitability and charitable contributions and even after taking those factors into consideration the hospital billing rates in Monterey County appear exceptionally high. In the interest of time, I only ask that you take into consideration why certain geographic areas seem to have very high or relatively low rates before setting any across the board limitations. Thank you.
5/12/23	Gerald Rogan	Reference: https://www.chcf.org/wp-content/uploads/2020/01/GettingAffordabilitySpendingTrendsWaste.pdf Below please find my comments. In general, to reduce health care costs one must identify which costs and mitigate them. Reducing costs by controlling global budgets will not work. 1. Problem: unnecessary imaging for low back pain. Solution: I wrote a Medicare LCD in 1998 to control this. The physicians accepted it. This kind of approach is necessary to control overuse of services. 2. Problem: Nationwide, overtreatment accounts for up to $76 to $101 billion in health spending annually. Solution: Find where there is waste, abuse, fraud and control it. Data analysis is required.

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		3. Problem: ordering a high-cost treatment when a lower-cost treatment could have resulted in equivalent or superior quality of care. Solutions: one can manage most ankle sprains in the ED without an X-ray Most urgent problems do not require an emergency department. 4. Problem: Further, excessive prices and overtreatment may be related: If providing services of little or no clinical value is profitable, some providers may continue to offer them despite the limited benefit Solution: more capitated managed care provided through fully integrated medical groups. Prices do not matter. No one pays retail. Reimbursement rates matter. 5. Problem: The most common low-value service was diagnostic imaging for uncomplicated headaches. Solution: require a second opinion by a neurologist for brain imaging in the absence of a neurologic finding. 6. Problem: $586 million in spending went to 44 low value services, including baseline lab tests for patients having low-risk surgery, annual cardiac screening for asymptomatic patients, and routine imaging for uncomplicated rhinosinusitis. Solution- identify the other 41 services. Do something about them. 7. Problem: But in other ways, prevention can increase costs when poorly targeted. most preventive services both add value to the health system and increase total costs. However, In many cases, preventive services enable people to live longer, healthier lives, making the services a good investment even if they cause overall health care spending to increase. Solution- don't expect better secondary and tertiary prevention to save money. 8. Problem: Failures of care coordination occur when a patient's care is disjointed, such as when there is poor communication across multiple providers caring for a patient, potentially leading to lapses, oversights, or redundancies in treatment. Solution- encourage urgent care services to be delivered as part of a primary care delivery system, not disjointed. 9. Problem: integrate and coordinate Medicare and Medi-Cal services for those eligible to participate in both programs Solution- mitigate fraud delivered to dual eligible patients. 10. Problem: California has several unique features that may contribute to high administrative costs. First, a ban on the corporate practice of medicine Solution- eliminate the corporate practice of medicine bar. It has been immolated by hospital medical care foundations that contract with physician groups.

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		11. Problem: Major fraud investigations have produced multiple criminal filings, which provide some sense of the magnitude of the problem in California Solution: Perform root cause analysis of fraud cases to discover potential remedies. Example, require a patient to validate every charge as they do for their credit cards. Use IT for our collective advantage. Identify a potentially unnecessary service before the bill is paid (applies to fee for service). 12. Problem: illegally paid the copays of thousands of Medicare patients who used the drugmaker's hypertension drugs, including Tracleer, Ventavis, Veletri, and Opsumit. Solution: find a way to mitigate unnecessary use of expensive "me too" drugs through "charitable" foundations that pay the copayment instead of the patient demanding a less costly drug. Attachment included: See Attachment #1 below.
5/13/23	Gerald Rogan	To reduce overutilization, HCAi must evaluate its data in detail, ask directed questions, discover the answers, then design corrective action that will work without impairing medical care, access, equity, or hassle the providers. I reviewed the most common conditions seen in the Emergency Department: Hospital Emergency Department - Diagnosis, Procedure, and External Cause Codes - 2021 Hospital Emergency Department - Diagnosis Code Frequency - California Health and Human Services Open Data Portal I was a board-certified ED doc with 7 years "in the pit". Some of the most common conditions are not appropriate for the emergency department. For example, the most common condition is hypertension. Other irrelevant conditions for the emergency department include hyperlipidemia, type 2 diabetes without complications, nicotine dependence, etc. This tells me the data collected is suboptimal. Why are ED docs or hospitals coding this way? Headache unspecified was seen 435,416 times. What was done for these patients? Question 1: How many of these encounters resulted in a test such as an MRI or CT scan? Question 2: How many of these scans were medically inappropriate? Method to find the answer: One must evaluate the data to discover the answer. If scans are overutilized, one must understand why a reasonable ED doc would order one. Then one can figure out what to do. A researcher must meet with ED docs to discuss the issue. This is the process I used to create local coverage decisions for Medicare. One LCD I created

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		controlled the unnecessary use of MRIs for low back pain. The docs agreed to it and followed the policy. Example 2: Circa 1978, before the MRI and CT scans were invented, ER docs ordered skull x-rays for minor head trauma for unscientific reasons. Once a study was published showing the x-rays were not medically necessary in patients with head trauma who did not lose consciousness and did not have neurologic findings, ED docs quit ordering the tests. This is the kind of process that must be done to reduce unnecessary utilization. Question 3: Is this excess utilization? Why do so many patients go to the ED for a headache? Would a visit to an urgent care facility be sufficient? How many of these patients were admitted? How many had a benign condition that could have been managed without an ED visit? If we find excess utilization, what can be done about it? Another example: How many ankle x-rays for ankle sprain are normal? What can we do to reduce the number of unnecessary ankle x-rays in the ED? What can we do to reduce the number of ED visits for ankle sprains? Urinary tract infection was seen 342,525 times. How many of these conditions can be treated with telemedicine or a visit to an urgent care? When there is no fever or back pain, most of them. What can be done? One of the reasons I opened an urgent care practice in 1980 was because I could treat a UTI at 1/5th the cost in an urgent care v. the ED. I was correct. Some of the conditions are less important to evaluate of overutilization, such as chest and abdominal pain. Recommendation: HCAi should have on its staff medical experts who understand these issues. California has several retired physicians like me who have worked in this field who can make themselves available to help. Obtaining the data is the first step. The next step is what to do about it that will work and is politically acceptable. Often additional data analysis is required. For example, how many MRIs and CT scans were done on these patients with headaches? Can we identify a pattern of medically inappropriate scanning? If yes, can anything be done to mitigate it? Many medical care plan medical directors specialized in this area, including me for Medicare. I have several friends who have done the same for Blue Shield and other private plans. Some live in Sacramento. I recommend HCAi leadership tap into the skills and experience available to you right here in Sacramento. In normal markets, where patients pay out of pocket, forces are at work to control unnecessary services. In Medical care, however, where some

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		patients pay nothing and don't know what they need, the drivers for overutilization require creative mitigation which is not easy to develop. The "devil is in the details".
5/17/23	Health Access	See attachment 2 below.

Attachment #1

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4/25/2017

Quality Improvement Organization (QIO)
12th Scope of Work
Special Meeting
7500 Security Blvd
Baltimore, Md.

Dear CMS:

This is an addendum to my 4/20/2017 comment already submitted, which is now recommendation 1 of 4:

RECOMMENDATION 1: Medical Disaster Analysis

Herein I propose that the 12th SOW for the QIO include a task to provide analyses of the root cause of medical disasters as defined below, report the findings to the public (with providers de-identified if required), and recommend corrective action.

If this task is successful, the effort could lead to the creation of a National Patient Safety Board whose task would be similar to the National Transportation Safety Board, as well as to other ad hoc investigations enacted in order to understand the root cause of various disasters, such as FEMA with Katrina, NASA with Challenger, and the Intelligence Community with 911.

QIO already has a function to motivate providers to improve quality and perform case review, to reduce adverse evented related to health care, to increase the value of health care, and to assist providers to understand the root cause of a concern in order to improve a process or system. The "Root Cause Analysis" (RCA) SOW is designed to be another task to accomplish the same goals.

The RCA task will make health care safer by identifying processes designed to assure patient safety within hospitals that have failed or were immolated resulting in patient harm.

For this task, a "medical disaster" is defined as

1. An occurrence of multiple cases within an institution the result of which was more than $1 million repaid to Medicare by one or more physicians at a hospital for medically unnecessary services provided to Medicare beneficiaries, whether by settlement or through court judgment; and which
2. Was brought to the government's attention via a Qui Tam (Whistleblower) action.

Two examples of cases that would have been subject to an RCA were those of Drs. Chae Moon and Fidel Relayvasquez at Redding Medical Center, Redding California 1997-2003[i] [ii] [iii] and Dr. Marc Midei, St. Joseph Hospital, Towson, Maryland, circa 2009.[iv]

In both of these examples, hundreds of patients were damaged, Medicare recovered millions of dollars, and the government agencies including the Medicare MAC failed to detect the problem (which is why a Qui Tam suit was filed in both cases). Following the RMC case, the deemed status of The Joint Commission was placed under CMS oversight.

In both hospital cases, no federal administrative entity performed a RCA. The RCA for RMC was performed by me and two co-author physicians from RMC. The RCA for SJH was performed by the Senate Finance Committee, Subcommittee on Health. There is no current routine process to provide RCA for medical disasters as is done for airplane crashes by the NTSB.

A few years ago, St Helena Hospital in California settled a Qui Tam lawsuit involving damage to many patients by a few cardiologists for provision of medically unnecessary services. Despite my request, the California QIO declined to provide a RCA because it is outside its SOW. Other agencies that declined include the OIG, FBI, State Licensing and Certification, California Medical Board, California Medical Association and its Quality Division, and CMS Regional Office 9.

My proposal is designed to rectify this situation. Failure to provide RCA for documented medical disasters is unacceptable. It would be equally unacceptable were there no RCA for the failures of FEMA, NASA, or the Intelligence Community. The NTSB provides RCAs for airplane crashes. The QIO should provide the same function for health care disasters, so we all can learn from proven mistakes.

In the cases of RMC and SJH, the failure discovered was a failure of medical peer review that was required of the medical staff pursuant to 42CFR 482.26 and related Medicare Conditions of Participation. But other causes of medical disasters may be discovered by the QIO, such as a failure of pharmacy services, nursing services, credentialing, etc.

Once the RCA reveals the problem, the QIO would propose remedies for review by CMS and its advisors. For example, if the RCA showed a failure of medical peer review, the hospital could be required to provide external peer review, as RMC offered to do, but never did. Alternatively, a hospital could be measured for effective peer review and the

results posted on Hospital Compare. Currently, there is no quality measure for failure to follow a process designed to assure quality.

The Department of Justice and the OIG/HHS probably can provide CMS with the number of Qui Tam settlements in excess of $1 million that involved provision of medically unnecessary services. CMS would use this data to develop a quantitative work plan for the QIO SOW.

If public reports cannot name specific providers due to court action or negotiations with the DOJ to assure the provider's name is not disclosed, the case file may be forwarded to the QIO with provider names redacted. Public reporting of the RCA of medical disasters should be required.

In the case of RMC, neither the A/B MAC contractor nor the Program Integrity Contractor had sufficient recourses to identify the malfeasance that generated the Qui Tam action and, eventually led to a $500,000,000 payment to CMS and exclusion of RMC from Medicare. The medical review of Dr. Moon was under my general guidance. I ordered the review but we did not have the resources to detect the medical negligence that cost Moon his license to practice. About two years ago, I contacted the PI contractor in Northern California to suggest a remedy to our failed medical review, so that this oversight, now performed by RACs, would be mitigated. Unfortunately, the same lack of resources abides. Consequently, we continue to experience provision of medically unnecessary services, Qui Tam law suits, and multi-million dollar settlements. Worse, we continue to learn nothing about the institutional failures we expect.

Routine RCA will let providers know that their malfeasance cannot go away by repayment of funds that were not originally payable. RCA will also provide case examples to show us where our current efforts are inadequate to assure patient safety, health care quality, and appropriate value. For example, perhaps some ineffective Medicare COPs need revision?

In order words, data analytics, and program integrity work is not sufficient. A successful Qui Tam law suit in health care is direct evidence of a regulatory and administrative failure. It is for this reason that I undertook an RCA. The RMC case was the worst disaster I witnessed in my medical career as a practitioner and as a Medicare MAC Medial Director. It is time to institutionalize the RCA activity, so that we can understand errors (including deliberate "errors"), our institutional provider failures, and the failure of CMS itself, so we can take appropriate corrective action which will lead to prevention of future abuse.

The QIO is the appropriate contractor to provide RCA. Eventually, if successful, this effort could lead to a National Patient Safety Board (NPSB) that operates under its own statutory authority.

In summary, a successful Qui Tam law suit in health care is direct evidence of failure of government oversight as well as of provider abuse of patients. The frequency of these cases will predict the amount to budget under the SOW.

RECOMMENDATION 2: Solicit institutional quality concerns from physician.

Reach out to docs to learn about quality concerns in the same manner as the QIO responds to patients and friends who call CMS with an allegation of a premature hospital discharges. To accomplish this task, as part of the task create a "physician ombudsman" QIO poster to be placed in medical staff lounges of every hospital stating

"Concerned about quality within your hospital and threatened by retaliation- call your QIO and let quality professionals investigate. All calls are confidential."

Rationale: Currently, sham peer review is used by hospitals and medical staffs to silence whistleblower physicians, including those who go through a hospital's chain of command. Several docs have contacted me asking how to report poor quality without endangering their practices (i.e. protect themselves from retaliation, such as via sham peer review). Providing poor quality as measured by unnecessary services is lucrative. Attempting to stop it can motivate retaliation. In response to this problem, around 2009 the State of California extended whistleblower protections to physician members of the medical staff of hospitals. But, the punishment is a misdemeanor and the fine no more than $25,000. The California Hospital Association opposed the new legislation. The legislature approved the bill with only one dissenting vote. The California Medical Association sponsored the legislation.

More work is needed to enable physicians who wish to report impaired patient safety to come forward without fear of retaliation. From time to time I receive calls from physicians who tell me about sham peer review or ask me to report a quality problem to the proper authority. One such case resulted in a State audit which found a preventable death following a repair of an abdominal aortic aneurysm. As a result, the hospital was decertified for these procedures because its volume was too low. Now such cases are referred to a regional center 15 miles away.

RECOMMENDATION 3: Follow off-label anti-cancer drug use.

Set up a process to collect more detailed data about off-label anti-cancer drug use in adults in coordination with a similar service spearheaded by the American Society of Clinical Oncology (ASCO). https://cancerlinq.org/

Rationale: CMS permits local part B contractors (MACs) to approve off-label use of anti-cancer drugs. This was part of my job as a part B CMD from 1997-2003. Approval is typically based on 2 studies which are insufficient to gain FDA approval for the use in controversy. Once approved off-label, patients have access to the drug, but additional research of its effectiveness is not required.

In order to better understand the efficacy and toxicity of off-label uses of anti-cancer drugs, more robust case reporting is required. Claims data is insufficiently granular for this purpose.

Off-label uses are those in which there is insufficient evidence for the FDA to conclude the drug is safe and effective for such use. Of course the absence of evidence of effectiveness is not evidence of ineffectiveness. Nonetheless, if Medicare is to continue to pay for expensive off-label treatments in adults, evidence of safety and effectiveness for the off-label drug treatment of adult cancer should be as robust as evidence provided for treatment of pediatric cancer. Treatment of pediatric cancer has improved much faster than treatment of adult cancer because the effects of off-label drug uses are typically collated and reported for children. We should do the same for adults. ASCO has spearheaded this effort and CMS should assist.

A more robust data base of the indications for off-label use and its effect will help research about real world use.

RECOMMENDATION 4: Audit coronary stenting.

The QIO shall audit a sample of coronary arteriograms which allegedly justify the placement of a coronary stent, in order to verify its medical necessity. Alternatively, the QIO shall require a hospital medical staff radiology department to audit a sample of coronary stents placed by cardiologists.

Rationale: Currently, the interpretation of a coronary arteriogram is performed by the same cardiologist who places the stent. In fee-for-service, this situation is an unmitigated conflict of interest. Widespread abuse is reported.

The RAC auditor I contacted about this last year does not have the resources to hire an expert to read the arteriograms to verify that stents placed are medically necessary, even for selected cases where abuse is more likely (e.g. when the high biller is in charge of peer review, and chief of the department).

Through QIO sponsored audits, conflicts of interest will be mitigated. CMS already requires that every 10th Pap smear slide read by a cytotechnologist must be over-read by a pathologist. So there is some precedent for my recommendation.

Thank you for the opportunity to comment.

Respectfully,

Gerald N. Rogan, MD
Medicare Consultant and Beneficiary

[i] http://roganconsulting.com/docs/Congressional_Report-Disaster_Analysis_RMC_6-1-08.pdf
[ii] https://www.youtube.com/watch?v=FmW-CAkI5Cc
[iii] Rogan Chapter in "The Truth about Big Medicine" https://www.amazon.com/Truth-About-Big-Medicine-Righting/dp/1442231602
[iv] https://www.finance.senate.gov/imo/media/doc/12062010%20Finance%20Committee%20Staff%20Report%20on%20Cardiac%20Stent%20Usage%20at%20St%20Joseph%20Medical%20Center.pdf

HEALTH ACCESS CALIFORNIA

May 16, 2023

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

Elizabeth Landsberg, Director
Department of Health Care Affordability and Information

Vishaal Pegany, Deputy Director
Department of Health Care Affordability and Information
Office of Health Care Affordability

Re: Comments on Health Care Affordability Board
April 25, 2023 Presentation

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

Health Access, the statewide health care consumer advocacy coalition committed to quality, affordable health care for all Californians offers comments on the presentation to the Health Care Affordability Board on April 25, 2023.

Introduction

In this letter, we offer recommendations and comments:

First, we formally request, that consistent with the statute, that measures of consumer affordability are tracked to measure the impacts of health care cost spending growth on consumer affordability of both care and coverage as well as the ability to afford other necessities of life and that this is discussed at a board meeting in the near future.

Second, with respect to "total" health care expenditures, we offer numerous recommendations including:

- Consistent with the statute, "total" health care expenditures should include spending by payers including health plans, health insurers and self-insured plans on covered benefits as well as, over time, the estimated spending on the uninsured and other sources of coverage such as Tricare, Veterans Administration, Federal Employees Health Benefits Program, and perhaps the Indian Health Services for covered benefits.

- We also recommend robust supplemental reporting that extends beyond "total" health care expenditures to include spending on such as public health, county behavioral health, corrections and workers compensation. We recommend this both because even

if health care programs are siloed, care is not and also because of the incorrigible inclination of the health care industry to shift costs to other siloes, especially when facing cost pressures.

- With respect to reporting on levels of "total" health care spending used in other states, this approach is insufficient to the scale and complexity of California.

Third, we recommend that from day one, "total" health care expenditures include Kaiser Permanente, risk bearing organizations and other "alternative payment models" that use capitation, salaried physicians or other approaches. Such approaches might be considered innovative elsewhere but that are long established in California and likely constitute a majority of health care spending by state-regulated health plans.

On the composition of the advisory committee, we recommend equal representation of the health care industry and purchasers of health care coverage as consumers, employers or trust funds for whom affordability of care and coverage is central.

Finally, with respect to the opportunity for public comment and Board process, we appreciate the agenda for the upcoming meeting and again express our dismay that "votes" of any sort were taken without any opportunity for public comment or further reflection by Board members.

Measures of Consumer Affordability

Health Access formally requests that the Board consider measures of consumer affordability to track and that a discussion of such measures be added to a future board meeting in the next few months as well as to the workplan for the Board and staff.

For the very beginning of the conversations conceiving the Office of Health Care Affordability in 2018, through the years of negotiations, the goal has been not just to contain costs globally, but to have a real impact on to achieve savings for California consumers. The two are related but savings for the system does not guarantee relief for patients or premium ratepayers. We learned this from our consumer advocate colleagues in Massachusetts, who regretted not tracking and prioritizing consumer affordability metrics from the beginning of their process.

Tracking consumer affordability impacts is clearly required in the California statute. For example, the law requires:

> (j) The office shall direct the public reporting of performance on the health care cost targets, which may include analysis of changes in total health care expenditures on an aggregate and per capita basis for all of the following:
> (1) Statewide.
> (2) By geographic region.
> (3) By insurance market and line of business, including for each payer.

(4) For health care entities, both unadjusted and using a risk adjustment methodology against the covered lives or patient populations, as applicable, for which they serve.
(5) For impact on affordability for consumers and purchasers of health care[1].

In our previous comments, we provided a brief overview of California-specific measures of consumer affordability. Unlike Massachusetts, the California law incorporates recognition of the importance of consumer affordability from Day One of the Office.

Unlike Massachusetts and some other states, but not all, California law incorporates a specific mechanism to assure that rate review by DMHC and CDI of health plans and insurers in the individual, small group and large group markets demonstrate how plans and insurers are accounting for spending targets in setting their rates. While this is only one mechanism, as Massachusetts recognized in its presentation to you, it is a useful one.

Consumer affordability measures tracked by OHCA should allow the Board and the staff to determine whether Californians of different income strata can afford care, coverage and other necessities of life. The regressivity of employer coverage worsens not only income-related social determinants of health but also is made worse by the lack of inter-generational wealth that is associated with other social determinants of health such as race and ethnicity. The California minimum wage of $15.50 an hour for 2023 means that a minimum wage worker who is a sole wage earner in a family of three or fewer is above the Medi-Cal income threshold for adults. Put another way, many minimum wage workers and those just above the minimum wage rely on regressive employer coverage for their health benefits. Even moderate-income Californians who rely on Covered California and make as little as $2,800 a month (250%FPL) face deductibles of $5,400 for the standard silver coverage or $6,300 for bronze, the most common choice for those in this income range[2]. The realities faced by low- and moderate-income Californians in affording care and coverage must come through loud and clear in the affordability measures tracked by OHCA and not be muffled by the high end of the income scale.

Total Health Care Expenditures:

Part One: Components and Categories of Spending

The law is plain that both claims-based payments and non-claims-based payments are to be included in "total" health care spending.

California health care already relies heavily on non-claims-based payments. Excluding or delaying reporting on non-claims-based payments would exclude:

[1] Health and Safety Code Section 127502 (j)
[2] 2024 Proposed Plan Designs_Side-by-Side View_Board_v2 PROPOSED 20230420.xlsx (coveredca.com)

- Kaiser Permanente which represents 35%-40% of most market segments[3]
- Risk bearing organizations which are medical groups that accept "full" risk which includes both professional services and institutional risk as well as those that accept "partial" risk
- 1206 L foundations, public entities and other arrangements which employ physicians rather than pay them on a claims basis.
- Risk taking by hospitals and health systems in the commercial and Medicare markets which is under-reported and perhaps not adequately regulated[4]
- Supplemental payments by both the Medi-Cal and Medicare programs such Disproportionate Share Hospital payments.

The illustrative list of non-claims-based payments included in the statute was intended to allow the Office and the Board a broad scope as well as to allow for inclusion or development of other categories of non-claims-based spending, including many of those listed as "other examples". It is important to distinguish between the reporting of health care costs incurred in prior years and the mission of the Office of Health Care Affordability to encourage transformation of the health care system to move toward the triple aim of lower costs, better outcomes and improved equity. The obligation of the Office to encourage alternative payment models falls into the larger effort of transformation, and as with the efforts of CMMI at the federal level, may require years or even decades to develop. While we look forward to the work of the Office and the Board to encourage the development of alternative payment models as part of the work of transforming the health delivery system as an ongoing effort, we strongly recommend against excluding or delaying inclusion of non-claims-based payments from the reporting of "total" health care expenditures while that policy work is pending.

In the discussion of what consumer cost sharing should be included in the presentation, much was made of the language on cost sharing "including but not limited to copayments, coinsurance and deductibles". This language is intended to capture all cost sharing, including any new ways of shifting costs to consumers by plans and providers. It is our understanding that reporting by the plans may be able to capture the difference between "provider paid" and "consumer paid" amounts: if so, then we recommend that this be done in order to provide data on what consumers spend out of pocket on covered benefits.

Another example of out-of-pocket spending may be consumer spending out of pocket and out of network on behavioral health because of the failure of health plans to assemble adequate networks of mental health providers. A recently enacted provision of California that requires plans to cover such care out of network when a plan is unable to provide timely access to mental health care may over time result in the inclusion of some of these costs in payer-reported data but that change is law is unlikely to fix the problem completely in the near

[3] 2022 Edition — California Health Insurance Enrollment (chcf.org)
[4] Observation from DMHC attempt to regulate such risk taking and proposed legislation in response, SB714 (Umberg), 2019, as introduced.

term. As discussed elsewhere, supplemental reporting with a California-specific focus can provide a rich source of information for the work of the Office and the Board in slowing the worsening lack of consumer affordability.

With respect to administrative costs and profits, we wholeheartedly agree with the discussion of the Board that particularly in California, there are a broad range of other administrative costs, and presumably profits, hiding in parts of the delegated market. The Board and the Office will have access to reporting on larger physician organizations that if done correctly, should provide information on administrative costs for those entities. Pending legislation, AB 616 Rodriguez, supported by Health Access, would make such information public on those larger physician organizations, including both risk bearing organizations regulated by the Department of Managed Health Care and other larger physician organizations that do not take risk in a manner that triggers regulation.

Part Two: Whose Spending?

Residents and Providers

While state employees work in a remarkable variety of locations and telecommuting has made out of state work for in-state firms more common, cross-border commuting remains relatively uncommon in California compared to geographically compact and contiguous states like Connecticut, Massachusetts, or Rhode Island. With the Pacific Ocean on the west, the Sierras and the desert to the east, and a large rural expanse north to the Oregon border, California remains an island on the land, in the words of Carey McWilliams.

The notable exception is Imperial and San Diego counties, where cross-border traffic is considerable. But obtaining cross-national health care spending data that sorts out California residents from other consumers seems rather challenging. SINSA, one of the main cross-border carriers, will not produce such data in our experience. Tahoe and Susanville are other exceptions.

We recommend that an effort be made to include the cost of caring for Californians in Nevada or Mexico, but we understand it may be difficult to do initially, and that it will have a minor impact on overall spending.

Other Sources of Coverage: Tricare, Veterans Administration, Indian Health Services, Federal Employees Health Benefit Program

From World War II through Vietnam and beyond, California served as a major staging area with numerous military bases. While that presence has diminished in recent decades, as the presentation notes, Tricare and VA remains significant sources of coverage for about 10% of the population. Many who receive care from the VA have other sources of coverage so there may be double-counting of spending and enrollees if this data is obtained.

While the presentation did not discuss the Indian Health Services or Federal Employees Health Benefit Program (FEHBP), both are commonly included in "total" health care expenditures.

For each of these sources of coverage, obtaining aggregate spending in California and sorting out any double-counting because of multiple sources of coverage for individual consumers may take time and staff resources. Because of this and the quick timeline for initial reporting of "total" health care expenditures, our suggestion is that data on these sources of coverage be added over time if it is not possible to add them initially.

Other Sources of Health Care:

Public Health, County Behavioral Health, Workers Compensation, Corrections

After reflection on the Board discussion and the work presented by staff and consultant, we urge the staff and the Board to make a clear distinction in its work between what it should track in the health care system, and what should be included in "total" health care spending that would be subject to growth targets and enforcement. The term "total" health care expenditures represents a subset of health care spending: that which is paid by health plans and insurers to doctors, hospitals, pharmacies for outpatient prescriptions, labs and imaging. This is a large subset of health care spending but only a subset.

We offer two recommendations:

- First, "total" health care spending on "covered benefits" should not initially include spending on public health, workers compensation or corrections and perhaps not county behavioral health because it detracts from the mission of improving consumer affordability of commercial coverage and because of numerous other challenges. The "total" health care expenditures measure consists of health care industry spending. In a health care industry that currently enjoys commercial payments of 450% of Medicare for some California hospitals and charges of 900% of Medicare (anesthesiologists), consistent reporting on health care industry spending is the foundation of addressing consumer affordability of commercial health insurance.
- Second, robust supplemental reporting on other health programs and areas should inform the broader health policy discussion in which the Board and staff is engaged. Tracking these costs is not the same as including these costs in the definition of "total" health care expenditures: our reading of the law suggests that the enabling statute does not include spending in these areas in the health spending to which the target applies. Robust supplemental reporting will provide the Board and staff important information on spending on other siloes in the health care system which interact with the health care industry but which are separate programs with separate policy objectives and funding streams.

Much of the discussion within the board about "total" health care spending revolved around the inclusion of elements of health care that have been siloed off with different administration and different funding streams separating those health systems from covered benefits paid by health plans, insurers, and other purchasers. This characterizes public health, county behavioral health, workers compensation and corrections. We would add that cost shifting across the silos is a persistent problem.

Points for the Board and staff to consider:

First and most importantly from our perspective, what is the core mission of the Office of Health Care Affordability? It is to focus on transforming the health system funded by commercial coverage and Medi-Cal (and interacting positively with Medicare funded care) so that the lack of affordability of commercial coverage and its regressive impacts are lessened while care and equity are improved.

Second, the differing policy objectives, siloed funding streams and separate administrative apparatuses of different programs will create significant challenges and delays in obtaining data on health services provided through public health, county behavioral health, corrections and workers compensation.

As an organization that has tried to plumb the mysteries of county realignment and county health budgets, our view is that the staff presentation significantly underestimates the complexity of including the public health spending of 58 counties and 3 local health departments, each with its own way of categorizing local budgets and local spending. The same is likely true of county behavioral health spending. This is complicated by the history of mistrust between the State and local governments since the enactment of Prop. 13 in 1978 and the ensuing web of ballot measures and litigation affecting state-local responsibilities and funding streams.

Correctional health with its history of a federal receiver and other troubles is similarly complicated by the role of local governments in the provision of jail and other correctional services. The move to incorporate health care received by prisoners, whether in the state correctional system or local jails, is an important topic and is shifting this conversation. Workers compensation insurance has a different set of carriers with different standards for care (and an important role in accountability for workplace safety not necessary in the rest of the health system).

The work that OHCA has ahead, both the Health Care Affordability Board and the HCAI staff, is already challenging and on a relatively short time frame. Setting a meaningful spending target that has the effect of improving consumer affordability of commercial coverage and lessening the regressive impacts of the lack of affordability today is at the heart of OHCA's mission. We also note that OHCA is not yet fully staffed or close to the anticipated level of capacity it will have in future years.

For the longer run, we support the inclination of Board members to be more inclusive in the costs that are tracked even if that broader universe of costs is not the subject of the cost growth target. The Board members articulated well the clinical reasons and the sense of the larger health system as a system in which the siloing of

funding and responsibilities is counterproductive to the larger mission of supporting the health of Californians. We also recognize the incorrigible inclination of elements of the health care industry to dump costs on consumers and public programs rather than engage in the work of transformation that was envisioned for OHCA. Tracking may require supplemental reporting.

A good example of this shifting of costs onto public programs is durable medical equipment. Many families in California with disabled family members rely on Medi-Cal, California Children's Services or the regional centers because of the abject failure of commercial health insurance to include most forms of durable medical equipment. Even something as obvious as diabetes supplies is only included in commercial coverage because of HMO reform in the 1990s. Even the very generous benefits provided by CalPERS coverage when combined with Medicare fails to cover such obviously necessary durable medical equipment as transit "options" for wheelchairs.

The Board, and this Administration, is well aware that behavioral health is another example of the abject failure of commercial health insurance to provide consumers affordable and timely access to the care they need. Those who can afford to pay cash and others suffer. This reality has led to a remarkably distorted delivery system for behavioral health in which providers rely on private pay rather than commercial coverage. While progress is being made, and OHCA is tasked with contributing to that progress, OHCA targets should not become an excuse for further shifting behavioral health costs on consumers and public programs. For that reason, the two responsibilities of OHCA work together: the responsibility to track out of pocket spending by consumers, including on out of network care, especially that care which should be provided in-network as well as the responsibility to encourage the transformation of the health care system through increased reliance on primary care and integration of behavioral health.

This is why our second recommendation is that over the longer run, HCAI and the Health Care Affordability Board should gather and track information on these areas of spending even if those areas are not included in "total" health care spending.

Spending by the Uninsured, Underinsured, Bad Debt and Uncompensated Care

After the expansion of Medi-Cal to the remaining undocumented, it is estimated that about 2.6 million Californians, or 7.9% of the population, will remain uninsured, including an estimated 710,000 who will be eligible for Medi-Cal but not enrolled[5]. California has made, and continues to make, incredible progress toward universal coverage but we are not there yet, with an uninsured population bigger than some states have people. Those who are eligible for Medi-Cal but not enrolled may well become enrolled if they have significant health care costs, particularly hospital costs. Under the current, definition, "total" health care spending by

[5] California's Uninsured in 2024: Medi-Cal expands to all low-income adults, but half a million undocumented Californians lack affordable coverage options - UC Berkeley Labor Center

payers does not include spending by the uninsured who are not covered with insurance, either public or private.

Spending by and on the underinsured, especially those with high deductible coverage, is not completely captured by "total" health care expenditures even if the payer reporting includes both "payer paid" and "consumer paid" amounts since a consumer may pay a portion of a deductible without paying the entire amount.

Supplemental reporting based on existing and potential data sources offers a way to provide some insight into spending by the uninsured themselves as well as spending by providers on the uninsured. Further research may well find additional data sources as well as open the possibility of adapting existing data sources to provide this information.

- Existing data sources:
    - HCAI, and its predecessor OSHPD, have been collecting data on hospital bad debt and uncompensated care since 1982. This data source may co-mingle the uninsured and underinsured and have other data problems but it is a well-established data source.
    - MEPS (Medical Expenditure Panel Survey) collects data on spending by the uninsured. This is a national survey with a sample size of 10,000. The sample probably includes fewer than 100 uninsured in California which raises concerns about data reliability and validity but it would provide some information. California-specific information should be available to HCAI if requested of AHRQ.

    - CHIS (California Health Information Survey)[6] is a state-level survey with a sample size of over 22,000. Current questions include questions on amount of medical debt, if any, and uninsurance status at the time the debt was incurred. Also included are questions on high deductible plans. CHIS surveys are updated regularly and can be adapted to meet changing state needs. For example, the current survey instrument includes questions on COVID-19.

    - Community Clinics Patients and Revenues: CHCF Safety Net Almanac[7] found that as of 2019, 19% of patients at community clinics were uninsured but only a small fraction of the revenue of clinics was 10% or less of revenue. Additional analysis could use the public domain data provided.

- Data sources that would require further research or additional development.

[6] About CHIS | UCLA Center for Health Policy Research. Design & Methods | UCLA Center for Health Policy Research
[7] California's Health Care Safety Net, 2021: Essential Access for Millions (chcf.org)

- County spending on the uninsured by county health systems, including county hospitals, county hospitals and contracting community clinics. Again, collecting data may be challenging and amounts spent by counties vary considerably.

- Additional research by CHCF on spending by the uninsured and underinsured in California as well as spending on the uninsured by providers. Given the wealth of research available from CHCF, the Foundation may be able to point staff to additional existing resources. CHCF's research agenda also focuses on important state initiatives and evolves over time.

Part Three: Population Denominator

We are puzzled by the either/or approach to a population denominator, suggesting that the choice is between membership figures reported by payer or the state's total population. Nothing in the statute prevents reporting both. And as the Board discussion suggested, there are advantages, and disadvantages, to each approach.

The Board should be provided with information further clarifying these denominators and their respective purposes. The statute provides that "total" health care expenditures on a statewide basis are reported on a "per capita" basis while its components which are attributable to specific payers, providers, or integrated delivery systems are measured on a per member basis. "Per member" level measurement of spending will assure entities are accountable for spending attributable to the individual member or patient.

Part Four: Reporting "Total" Health Care Spending

It is necessary but not sufficient for a state the size of California to report "total" health care expenditures at the market level. A few examples of why that is insufficient:

- Medicaid managed care in California has about 12 million enrollees, more than the population of 42 other states, including states such as Georgia and New Jersey, not particularly small states.

- Similarly, Medicare Advantage includes almost 3 million Californians, larger than the population of twenty states[8].

Perhaps such categories are useful in other states for tracking trends: here this approach seems insufficient and should be more granular.

[8] 2022 Edition — California Health Insurance Enrollment (chcf.org) and U.S. States Populations, Land Area, and Population Density (states101.com)

For California, this approach would mask considerable variation both by market segment and geographic region. For example, many academic analyses of California data on the commercial market separate Kaiser/not-Kaiser. Similarly, it is well established by numerous studies that there is considerable North-South variation. The Board has already heard from those in Monterey County suffering from the extraordinarily high hospital costs in that county, so high that some employer coverage there offers transportation to Stanford Health System as the low-cost alternative.

For a state the scale of California, both statewide reporting at the "market" level and reporting at a level more granular than the 3 million Medicare Advantage enrollees, 12 million Medi-Cal managed care consumers or 14 million consumers in state-regulated, commercial coverage is necessary in order to provide meaningful reporting. We would benefit from a discussion of the Board on whether this is at a regional level or by some other increment. But limiting reporting standards to those developed for states with populations smaller than many California counties will not provide sufficient information about health care spending in California. What is appropriate in a state with three million people or even seven million people is not sufficient for 39 million Californians. The choice of how to create increments can be preliminary with an expectation of revisiting them in future years but smaller increments than 12 or 14 million consumers is in order.

Advisory Committee Applications

The creation of a subcommittee of the Board to discuss parameters for the statutorily-mandated advisory committee as well as guidance on possible members is an important step forward.

A few observations on the advisory committee membership from our perspective as a consumer advocacy organization:

- First, there is much to commend the Oregon approach which balances the health care industry with those who purchase coverage with a 50/50 split. Here in California purchasers would include employers, union trust funds, and organizations such as ours that represent consumers and patients.
- Second, it is important to guard against real or perceived conflicts of interest, whether it is purchasers or consumers. We note that many business organizations allow representatives of the health care industry such as hospitals, health plans, and pharmaceutical manufacturers to dominate the policy positions of those business organizations on health care. Similarly, some "patient" organizations are substantially funded by the relevant pharmaceutical manufacturers for the particular condition. In our experience of legislative fights on health care costs, some of these organizations fall on the industry side of the ledger, not the purchaser side.

- Third, while there is a desire to assure broad representation and to tap the expertise of the various elements of the industry as well as purchasers, this needs to be balanced by creating a committee with a workable size.

- Finally, just as we have actively participated in the public process available at the Health Care Affordability Board, including by providing public testimony and writing this and other letters, that same opportunity is open to any representative of the health care industry that wishes to make their voice heard.

Board Process and Responsibilities

We appreciate that the recently posted agenda for the May 2023 meeting separates discussion items and action items. As we said in our verbal testimony, we were dismayed that the board took votes on the important substance presented at the April 25, 2023. Even though these were characterized as "preliminary decisions", they were votes on decisions. We appreciate the May 2023 board agenda uses the model used by Covered California board meetings in which a topic is discussed at one meeting and action taken at a subsequent meeting. This allows time for both further board consideration, staff work and public input. Instead votes on a number of topics were taken without any public input and at the first meeting at which such important topics were discussed.

We have learned subsequently that the determination of how to measure "total" health care spending is a determination of HCAI rather than the Health Care Affordability Board. This leads us to another process observation: given the complicated division of labor between the staff and the Board, it would help if who is responsible for what is made clear in writing when a topic is introduced. This was mentioned verbally by the Director but we would appreciate inclusion of this important point in the written materials.

We recognize that the April 2023 meeting was only the second meeting of the Board. Some of us were present for the creation of Covered California a dozen years ago and remember a bump or two in that process as well. But it is also the case that the early meetings and process are important because what is newly created now will quickly become habit and tradition that are difficult to revisit.

Finally, we appreciate the posting of these formal comments along with the meeting packet.

Thank you for your consideration of these comments, and we look forward to our continued work together to establish a successful Office of Health Care Affordability to benefit California consumers, patients, payers, and purchasers, and the system as a whole.

Sincerely,

Beth Capell, Ph.D. — Policy consultant/advocate

Anthony Wright — Executive Director

CC: Members of the Health Care Affordability Board
Jim Wood, DDS, Chair, Assembly Health Committee
Susan Eggman, LCSW, Chair, Senate Health Committee
Joaquin Arambula, M.D., Assembly Budget Subcommittee
Caroline Menjivar, Senate Budget Subcommittee
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