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Health Care Affordability Board
August 22, 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
9/12/2023	Ben Johnson for California Hospital Association	See Attachment #1.
9/13/2023	Janice Rocco for California Medical Association	Please see the attached comment letter from the California Medical Association about the Cost and Market Impact Review (CMIR) proposed draft regulations, which is Item #4 on the Agenda for the September 19th Health Care Affordability Board meeting. Thank you. See Attachment #2.
9/15/2023	Beth Capell and Anthony Wright on behalf of Health Access	See Attachment #3.

California Hospital Association

September 12, 2023

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

SUBJECT: Comments on the August 2023 Health Care Affordability Board Meeting

Dear Dr. Ghaly:

California's hospitals share the Office of Health Care Affordability's (office) commitment to making sure patients receive high-quality, timely, equitable, and affordable health care. On behalf of its more than 400 hospital and health system members, the California Hospital Association (CHA) appreciates the opportunity to comment on the August 2023 proceedings of the Health Care Affordability Board.

Draft Cost and Market Impact Review Regulations

We appreciate the office's commitment to a robust public process by providing advance notice and an opportunity for stakeholder feedback on the draft proposed regulations. However, we have significant substantive concerns about the July 27, 2023 version of the draft regulations. Our concerns echo those raised by board members at the August Health Care Affordability Board meeting, who expressed worries about the office seeking to collect too much information, from too many entities, about too broad a set of transactions. A particular concern we heard from board members related to the impact that these draft regulations would have on rural health care providers who are struggling to keep their doors open and have the least capacity to comply with a new and burdensome set of regulatory requirements.

The recent closure of Madera Community Hospital shows what can happen when state regulatory processes come into conflict with the needed speedy resolution of a collaboration to save a provider in severe financial distress. As the office finalizes its draft regulations on the cost and market impact review (CMIR) process, we urge it to consider the potential ramifications of asserting overly broad authority to review even small and routine transactions; the expense, time, and uncertainty the process adds for these basic market activities; and the potential for overly burdensome regulations to ultimately undermine the enabling statute's foundational goals of improving access to high-quality, equitable, and affordable care.

We recommend that the office reconsider its current approach of seeking maximal noticing, information submission, and timeline authority at the outset to one that focuses on the key areas of concern and clear statutory prerogatives. Then, over time and using its streamlined (emergency) rulemaking power, the office may progressively expand the scope of its market oversight functions to the extent that experience shows this is needed. Below is a summary of our central concerns and feedback.

Focus on the Most Impactful Transactions. As drafted, the regulations establish noticing and materiality requirements that would capture an enormous array of basic market and operations activities that extend far beyond what was intended by the authorizing legislation. Consistent with concerns raised by board members, we urge the office to substantially narrow the draft regulations to focus its efforts on transactions likely to have significant effects on the health care market. Doing so would accord with the intent of statute and ultimately prevent the office from being overwhelmed by notices and information from filing entities, while also lightening the burden placed on health care entities — including small and rural health providers — that seek business and operational relationships to continue delivering accessible and high-quality care in their communities.

- **Exempt Transactions in the Ordinary Course of Business.** Due to its overly broad definition of a "transaction," the current draft regulations would require 90-day notice for changes in operations above a given dollar threshold. For many providers, this would include routine transactions such as contracting with a health plan to be an in-network provider, updating an electronic medical record system, securing a loan, or leasing new medical office space. Mandating advance notice and subjecting health care entities to a costly and slow review process for the hundreds or thousands of such transactions that they conduct annually is neither what the Legislature intended nor what would be conducive to a functioning health care delivery system. The regulations must be revised to categorically exempt transactions in the ordinary course of business from the definition of a transaction, or enumerate an expansive list of transactions explicitly exempted from office oversight under the CMIR process.
- **Conform to the Materiality Requirements in Statute.** State statute requires notice of a material change only when a health care entity *transfers* "a material amount of its assets to one or more entities" or *transfers* control, responsibility, or governance of "a material amount of the assets or operations *to one or more entities*." In other words, each paragraph of the relevant section of the draft regulations (subdivision (c), specifically) must include both of the following:
    - A *transfer* of assets or control
    - A threshold dollar amount of assets and/or threshold measure of control *that is being transferred*

  Several of the conditions requiring notice of a material change under the regulations fail to comply with this statutory imperative. These include the conditions requiring notice for transactions that raise revenues by $10 million (even for entities making tens of billions of dollars annually), affiliations where an entity has $10 million in annual revenue, and transactions among parties that have previously consummated another transaction. CHA recommends that these conditions be deleted or, at the very least, be better defined to include a *transfer* of a *material amount* of assets or control in order to comply with the governing statute.
- **Establish Reasonable Asset Transfer Materiality Thresholds Pegged to Inflation**. The $25 million threshold for providing notice of a material change is much too low, neither recognizing the size of California nor the 30% inflation that has occurred since Massachusetts set the precedent for this threshold. To prevent ever smaller transactions (in real dollar terms) from falling under the review process, CHA recommends that any adopted threshold be updated regularly to account for inflation. To address both these concerns we recommend adopting the Federal Trade Commission benchmark.
- **Conform With the Generally Accepted Definition of "Control."** The draft regulations define a change in control as a transaction that transfers more than 10% of the control of a health care entity. This threshold is far too low. A person or corporation with a 10% interest in a health care entity does not, under any scenario, have control over the health care entity. Moreover, the

threshold belies substantial legal precedent as to the meaning of "control." Both the California Corporations Code and the Federal Trade Commission set a 50% threshold for defining control. As a rule of statutory construction, the Legislature is presumed to know existing law when enacting new laws. As such, it undoubtedly knew the definition of "control" and chose to use that term in the governing statute. We recommend the 50% threshold be adopted.

Establish Clear and Speedy Timelines. Under the current draft regulations, the full CMIR process would take a minimum of 250 days — over two months longer than Oregon's comparable deadline. Unfortunately, we do not believe the deadlines established in the draft regulation would represent maximum timelines applicable to only the most complex transactions. Rather, based on our extensive experience under similar review processes from another state agency, the deadlines would represent the norm. Such drawn-out timelines would add hundreds of thousands of dollars to the cost of transactions and produce a chilling effect on prospective collaborations, regardless of how beneficial the arrangement would be to California patients and communities.

As one board member described at the August meeting, a delay can kill a transaction. To prevent the discouragement of constructive collaborations, prolonged uncertainty surrounding the outcome of a proposed transaction, and inadvertently raising health care costs, we urge the office to expedite and clarify its timelines for the CMIR process. We request several practical changes to deadlines to reduce the timeline to 200 days — comparable to that in other states. We further ask the office to:

- Clarify the office's missing deadline for publishing preliminary reviews
- Establish reasonable protections against overly long and potentially unrestricted tolling against the office's deadlines
- Simplify the reference date for "closing" a transaction
- Create an expedited review process for urgent transactions
- Adopt additional reasonable rules that hold the office accountable to achieving its deadlines

Establish Reasonable Fees for CMIR Activities. Existing governmental reviews of arrangements among health care entities regularly entail hundreds of thousands of dollars in costs to reimburse government agencies for their use of outside consultants and experts. Because government agencies simply pass along these costs to regulated entities, the fees charged by consultants to government agencies often greatly exceed the amounts these same consultants charge directly to health care entities for similar work. For this reason, and to comply with statutory requirements, it is critical for the office to put in place reasonable protections regarding the fees that will be charged to health care entities under the CMIR process. We ask the office to include in the revised regulations a provision that will ensure that fees charged are reasonable and accord with the economical costs of conducting a review.

Ensure Benefits of Proposed Transactions Are Given Appropriate Consideration. The office's authorizing statute requires that the benefits of proposed transactions be considered in the CMIR process. However, the proposed regulations are silent on whether and how the office would consider these benefits. The regulations must be revised to affirm and enumerate the office's responsibilities to give the benefits of proposed transactions their proper consideration.

Clearly Formulate Criteria for Determining Whether to Conduct a Full CMIR. While the draft regulations list the factors the office would consider when determining whether to conduct or waive a full CMIR, they provide no clarity about how the office would evaluate those factors. In fact, the draft

regulations allow the office to make arbitrary decisions about which transactions will be subject to a CMIR based entirely on lax speculation. As a result, health care entities would have little to no ability to anticipate whether an intended transaction will be delayed by 250 or more days. Moreover, the automatic inclusion of any transaction involving a general acute care or specialty hospital shows a preconceived and undeserved bias by the office against hospitals and hospital transactions. We strongly encourage the office to clarify the criteria via regulation to identify when a CMIR will be required and, in doing so, conform with the statute.

Reasonable Information Submission Requirements for Parties to a Transaction. Overly expansive information submission requirements on parties to a transaction place unnecessary burdens on health care entities, increase compliance costs, and exacerbate the risk that sensitive and confidential information will be released into the public domain. Accordingly, in identifying the information parties to a transaction must submit prior to and during the CMIR process, the office must seek to gather the minimum kinds and amounts of information necessary to fulfill its statutory prerogatives. The information submission requirements — as currently drafted — should be scaled back to balance the office's need for information with the negative impacts that overly onerous reporting requirements would have on health care entities' basic market activities. In addition to several other requested changes, we recommend the office limit the submission requirements accompanying an initial notice of a material change to those of Massachusetts and Oregon, as well as California state agencies, including the Department of Justice. Additional information necessary to inform a full CMIR should be collected only when the office elects to conduct a full review following a waiver decision.

Protect Sensitive Non-Public Information Provided to the Office. Health care entities maintain large amounts of data to fulfill their patients' clinical needs, manage their finances and operations, and compete in the health care marketplace. Protecting the confidentiality of these data is critical. We appreciate that the office has the difficult task of balancing public transparency with the parties' rights to keep sensitive proprietary information confidential. CHA recommends that Hart-Scott-Rodino filings and contact information for individuals other than the designated public contact be deemed confidential. In addition, we request that the office establish a process to inform the submitter if it denies a confidentiality request and provide an opportunity for the submitter to appeal the denial before the office makes the information public.

Total Health Care Expenditures

Patient Attribution Challenges Raise Concerns. We appreciate the ongoing public discussions over the office's approach to patient attribution under the spending target program. Given that the credibility of the spending target program rests on the accuracy of the patient-attribution process, it is essential to get the rules right at the outset. Such rules must aim to significantly limit false positives in the form of misattributing a patient to a provider in situations where the provider has no real influence or control over the medical spending and utilization of the patient. In addition to engaging *payers* early in the development of related policies and procedures, we request early and ongoing engagement with *providers*. Ultimately, we hope to see the office set clear and consistent standards for patient attribution across payers and allow providers to validate the patient attribution data submitted by payers.

Spending Targets Must Balance Multiple Objectives and Account for Various Factors. We understand that in September the board will begin focused discussions on spending target methodologies ahead of

adopting the first non-enforceable spending target in June 2024. To prepare for these discussions, we highlight the following key requirement in the statute, which says that spending targets must:

> "Promote the goal of improved affordability for consumers and purchasers of health care, while maintaining quality and equitable care, including consideration of the impact on persons with disabilities and chronic illness."

Over the next several board meetings, we ask for careful discussion and consideration of each of the above elements laid out in law. In doing so before actually setting the state's spending target and associated methodologies, the office and board can ensure they are fulfilling each of the multiple objectives established in state law. Below, we offer several considerations related to statutory requirements applicable to the state's future spending targets.

- **Affordability.** California's hospitals share the office's goal of promoting affordable care, recognizing the concerns of Californians related to health care cost growth and the burden that cost sharing has on workers and patients. Furthermore, we recognize the inefficiencies in the U.S. health care sector, which are clearly summarized in a 2019 JAMA article.[1] Such inefficiencies are due to several factors, including:
    - Huge administrative challenges imposed on providers due to a lack of standardization in payer policies — the largest single factor identified in the JAMA study.
    - High costs for pharmaceuticals and certain other services – with pharmaceutical pricing failures being overwhelmingly implicated in the JAMA study.
    - Failures to provide appropriate preventive care and therefore providing more treatment than is necessary in acute care settings — the third-largest factor identified in the JAMA study.
    - Enormous complexity within our systems of care without adequate resources dedicated to helping coordinate care — a factor implicated in the overreliance on acute care.

  We believe that the office's prerogative must be to address affordability challenges that are due to inefficiencies such as those described above. Success cannot mean lowering costs at the expense of equitable access to high-quality care. Therefore, in setting, monitoring, and enforcing the state's spending targets and related policies, the office and board must remain steadfastly focused on the objectives of improving the value proposition and cost-effectiveness of care — rather than myopically cutting costs. Moreover, the office and board must recognize that achieving practice transformation to improve the value of care will take time, which must be accounted for in how the state's spending targets are initially implemented.
- **Quality.** State statute contains a potential contradiction: it has the state's spending targets taking effect beginning in 2025 while requiring that they be established in a manner that maintains quality. And yet, the statute does not require the office to set and measure quality standards until midway through 2026. This puts the cart before the horse by asking the office and board to say how much the state should spend on health care before deciding on what we want our health care system to achieve. We therefore ask the office to accelerate its consideration of how quality — and value more broadly — is to be maintained and improved within the context of

[1] Shrank, William H., et al. "Waste in the US Health Care System." *JAMA*, vol. 322, no. 15, 7 Oct. 2019.

the state's spending targets. While standard measures such as well-child visits and control of diabetes should be part of these discussions, we urge the office to look at additional measures of the overall health care system's performance. Are wait times for primary care and specialty visits increasing or decreasing? Are travel times to emergency care going up or down?[2] Are new medical technologies diffusing and becoming available as quickly as possible? Are new and effective care modalities such as Hospital at Home and telehealth being adopted? Patients want these improvements and innovations — they don't want the same access to the same treatments and care that have historically been available. Accordingly, monitoring macro trends such as those listed above is an important role for the office to play to prevent unintended consequences from its regulatory activities.

- **Equity.** Unequal access to health care and health resources is a major driver of health disparities. This is why investments are needed to eliminate disparities in access to not only traditional health care services but also social supports and care management services. The office's spending targets and related policies must recognize the need for and impacts of these new investments. If spending targets are set, monitored, and enforced without such recognition, they will serve to discourage the investments and punish those health care entities that nevertheless make them, undermining a critical pillar of the office's work. For example, the managed care organization tax agreement recently enacted will support increased payments to providers to address structural inequities in access to care for Medi-Cal beneficiaries. This will raise providers' revenues, increasing the risk that they run afoul of the state's spending target and are subject to the lengthy and costly enforcement process. Above and beyond public policy changes, hospitals regularly make investments and undertake other initiatives to address health inequities in their communities. As the office and board shift to thinking about establishing spending targets, we recommend that the question of how to incorporate equity into the spending target program remain at the forefront of policymakers' minds.

Thank you for the opportunity to comment on the August board meeting.

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

[2] See the following study for the impact of higher emergency transport time on mortality rates from cardiac arrest: Jena, Anupam B., et al. "Delays in Emergency Care and Mortality during Major U.S. Marathons." *New England Journal of Medicine*, vol. 376, no. 15, 13 Apr. 2017, pp. 1441–1450, https://doi.org/10.1056/nejmsa1614073.

CALIFORNIA MEDICAL ASSOCIATION

August 31, 2023

Megan Brubaker
Office of Health Care Affordability
2020 West El Camino Avenue, Suite 1200
Sacramento, CA 95833

Sent via email: *CMIR@hcai.ca.gov*

Re: "Promotion of Competitive Health Care Markets" draft regulations

Dear Ms. Brubaker:

On behalf of the California Medical Association (CMA) and our nearly 50,000 physician and medical student members, CMA would like to thank the Office of Health Care Affordability (OHCA) for the opportunity to comment on these draft regulations and requests that substantial changes be made before sharing your next draft. It is helpful that the statute provides for your draft regulations to go before the Health Care Affordability Board, as that provided an additional opportunity to hear from stakeholders, including CMA, in addition to the feedback you received from Board members about necessary changes to the draft.

CMA broadly outlined our concerns at OHCA's August 15, 2023 Public Workshop about the proposed emergency regulations. This letter addresses those broad concerns. CMA will follow up with specific amendments and more detailed comments, as warranted, in subsequent public comment periods, and after discussing these issues with OHCA staff and gaining a better understanding of the expectations for next steps given the significant concerns that have been raised about the first draft.

The statute calls on OHCA to review transactions likely to significantly impact market competition, the state's ability to meet cost targets, or affordability for consumers and purchasers. As we read the "Promotion of Competitive Health Care Markets" draft regulations, we are paying particular attention to any of the provisions that fail to meet the standards for rulemaking such as clarity, consistency, and authority. We are also focused on areas in which the draft regulations may deviate from the intent of the statute, increase administrative burden, increase costs, or have a negative impact on the health care delivery system and patient access to care.

One concern shared by many parties is the length of time the proposed Notice of Material Change and Cost and Market Impact Review (CMIR) process would take under these draft regulations. This would be a costly and time-consuming process for the parties, and for OHCA. It is not in the best interest of health care consumers for health care entities to be required to compile the substantial information required in the notice of material change for every small, commonplace, routine transaction that is unlikely to significantly impact

competition or affordability. The current draft includes commonplace transactions that don't involve the transfer of "a material amount of the assets" of a party, which is the triggering threshold in the statute.

For those transactions that do warrant a CMIR, we would urge you to streamline the process, so that reviews don't take ten months or longer. A lengthy process will discourage many small transactions that might improve patient access to care from occurring and will likely prevent other small transactions from coming to completion once a notice of material change is submitted to OHCA. Even for larger transactions, the review process should not take more than a few months. OHCA's role is to identify transactions that are "likely to have a risk of a significant impact on market competitions, the state's ability to meet cost targets, or costs for purchasers and consumers" and then refer such a proposed transaction to another state entity with the authority to take action. (Health & Safety Code § 127507.2(a)(1).) The Office's purpose is not to create a situation in which those unlikely to ever meet that threshold collapse during the lengthy review process or a small or distressed entity is forced to close.

Many of the triggers in draft § 97435(c) and the corresponding provisions in (e) have such low thresholds that the Office would likely receive thousands of unnecessary filings each year and have to review and sort through them before it could focus on those the statute intends for OHCA to examine. For example, if a health care entity intends to have "a substitution of one or more members of the governing body", that would trigger the requirement to submit a notice of material change. The substitution of one member should not trigger such a filing and the associated requirement to wait at least 60 days to hear back from OHCA.

OHCA was granted emergency rulemaking authority until January 1, 2027. For this and many other reasons, CMA urges OHCA to focus your early attentions on transactions larger than the thresholds proposed in draft § 97435(c). Once the Office has had a year or two of experience, it can use its emergency rulemaking authority to expand the volume of transactions that necessitate a notice of material change or a CMIR if you learn that an initial focused set of regulations is not bringing to OHCA all the transactions that warrant your review. Inundating the Office with thousands of notices that must be reviewed and responded to will delay review of the more significant transactions. Additionally, you will gain knowledge from your first year of experience with the review process (including ways to streamline it), and you will be able to increase staffing to handle a higher volume of submissions over time.

If OHCA keeps any of the triggers in draft § 97435(c), it would be helpful to clarify that the triggers in (c) are only relevant when an entity in (b) is involved in one of these transactions. We appreciate the OHCA staff's comments at the Health Care Affordability Board meeting that that (c) is not intended to apply unless at least one of the parties meets the definition of health care entity, but the triggers in (c) are such low thresholds that many have read (c) to pull in transactions involving two parties that are both exempt under the statute by virtue of having fewer than twenty-five physicians in each entity.

Some of the definitions in the draft regulations are inconsistent with the definitions in statute. The definition of health care entity in the draft regulations should not be broader than in Health and Safety Code § 127500.2, so, as an example, management services

organizations (MSO) which were excluded from the statute should not be included in the regulations, nor should affiliates, subsidiaries or other entities related to health care entities unless they, too, satisfy the definition.

The definition of "health care services" in the draft regulations is so broad it is not focused on market competition and includes:

- Performance of functions to refer, arrange, or coordinate care;
- Equipment used such as durable medical equipment, diagnostic, surgical devices, or infusion; and
- Technology associated with the provision of services or telehealth, electronic health records, software, claims processing, or utilization systems.

The description in draft § 97441 of how OHCA would determine whether to conduct a CMIR goes beyond the statutory authority in terms of what would trigger a CMIR.

At the same time, some of the provisions in the draft regulations lack clarity. These in part include:

- Draft § 97435(e)(3): It is unclear what constitutes "administrative or operational control or governance" and how one would quantify the administrative/operational control or governance that would be transferred to ascertain whether a contemplated transaction triggers the 10% transfer threshold requiring a material change notice. Additionally, the 10% threshold is quite low and would likely result in unnecessary filings for transactions the statute does not intend to include in this process.

- Draft § 97441(a): Rather than to make the statutory mandate of § 127507.2(a)(1) more specific, this subdivision provides a vague set of standards for when a transaction warrants a CMIR. The factors in paragraph (a)(2) of the draft section are drafted in such uncertain, open-ended terms, that the parties directly affected by these draft regulations would have no reasonable understanding of whether a transaction is likely to advance to CMIR. The Office's CMIR determination would be a highly subjective and arbitrary process, which invites an inconsistent application of standards and potential legal challenges over alleged abuse of discretion. Use of "may"—which expresses possibility, not probability, propensity, or likelihood—in many of the subparagraphs under paragraph (a)(2) makes these factors applicable to practically any transaction. Thus, the scope of transactions that could be deemed to meet "any one" of these open-ended, vague factors is boundless, and much broader than the statutory bar of transactions that are "likely" to have a "significant" impact on competition, costs, and cost targets.

- Draft § 97441(b): It is unclear when a notice would be considered "complete" and when the 60-day review timeline would be expected to conclude. This is in part due to the broad and extensive list of information required in draft § 97439, some of which consists of vague or open-ended narrative components; and in part due to the Office's ability to toll the deadline indefinitely with requests for additional information, including those not required as part of the MCN filing as described in draft § 97439.

We know OHCA does not in any way intend to decrease access to health care or to exacerbate existing inequities, but anything that disincentivizes physicians and others from providing care in rural areas or health professional shortage areas is something that should be avoided, so we request that you delete paragraph (b)(3) of draft § 97435.

CMA is also concerned that the potential costs, delays, and uncertainty around the ability of parties to execute transactions as a result of the draft regulations could thwart the primary remit of the Office (reducing cost growth and promoting competition) by adding substantial new costs to California's health care market, increasing barriers to entry, and making transactions more difficult and costly. An overly broad scope hurts smaller and mid-sized entities contemplating a joint venture or other transaction that could otherwise improve competition. Some smaller entities may not survive as a result of the added costs and difficulty to enter into a transaction with a strategic partner. Larger health care entities are likely to benefit. These potential impacts underscore the need to take a deliberate and measured approach in implementing the Office's cost and market impact review program.

The statute indicates that OHCA will set fees through regulations, and those fees should be included in these regulations. Parties should have an estimate of what level of fees they will pay if they file with OHCA so they can make appropriate business decisions. During the Health Care Affordability Board's August 22, 2023 meeting, it sounded like the intent is to contract out the CMIR work, rather than hiring staff with subject matter expertise and developing that expertise in-house. Relying on contractors gives OHCA leadership less ability to monitor the work, may result in health care consultants having confidential information that could later harm the parties that filed the information, increases the likelihood of conflicts of interest and is likely to be significantly more costly for the health care entities that must file.

In summary, we ask that OHCA's regulations be consistent with the intent of the statute to focus on the transactions likely to significantly impact competition, the state's ability to meet cost targets or affordability for consumers and purchasers. We further urge OHCA to reduce the volume of information that must be submitted as part of the notice of material change, shorten the timeline for the CMIRs and set reasonable fees for the CMIR process. We appreciate your willingness to discuss these issues further.

Sincerely,

Janice Rocco
Chief of Staff
California Medical Association

cc: Members of the Health Care Affordability Board

HEALTH ACCESS CALIFORNIA

September 15, 2023

Mark Ghaly, M.D., Chair
Health Care Affordability Board
Secretary, California Health and Human Services Agency

Elizabeth Landsberg, Director
Department of Health Care Access and Information

Vishaal Pegany, Deputy Director
Office of Health Care Affordability

2020 W. El Camino
Sacramento, CA

CC: Megan Brubaker, HCAI

Re: August 22, 2023, Board Meeting and September 19, 2023, 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, offers comments on the discussion at the August 22, 2023, meeting of the Health Care Affordability Board and in preparation for the September 19, 2023, Board meeting.

<u>Consumer Affordability Measures</u>

Health Access again urges that in tracking "total health care spending," the Office track "consumer paid" and "payer paid" separately so that the Office may, in part, fulfill its statutory obligation to track consumer affordability.

In addition, Health Access urges tracking of additional metrics that capture the cost of care and coverage as well as the impacts of the lack of affordability. The phrase "the cost of care and coverage" includes cost sharing, employee share of premium and employer

share of premium. The employee share of premium impacts workers because it is part of employee compensation. Shifting the increasing cost of coverage among the three buckets has been used as a method of attempting to control the cost of health care on the theory that if consumers had "skin in the game" somehow that would result in doctors, hospitals and pharmaceutical manufacturers lowering costs. This approach has failed to slow the rate of growth of costs. Instead, this approach leads to other, predictable ill effects:

- Shifting the cost from the employer share of premium to the employee share of premium increases the number of Californians for whom the cost of coverage is out of reach.
- Shifting the cost from premiums to employee cost sharing such as deductibles, copays and coinsurance increases medical debt, leads consumers to avoid or delay necessary and appropriate care, and worsens the ability to afford other necessities of life.
- Requiring employers to pay ever higher premiums also increases the number of uninsured and shifts costs to public programs.

The failure of this approach to control health care cost growth by shifting ever escalating costs among the buckets of premiums, share of premium and cost sharing explains the rationale for the creation of the Office of Health Care Affordability. It is incumbent on the Office to measure the impacts of the cost of care and coverage by looking at indicators of cost sharing, premiums, and collateral damage in the form of medical debt, avoided care and other impacts. If the Office does not measure these impacts, we will miss key pieces of the overall puzzle of containing health costs and allow unintended consequences.

<u>Economic Indicators to Use for Spending Target</u>

The spending target particularly for employer coverage and individual coverage should be based on a measure or measures that reflect the ability of consumers to afford care and coverage, not the wealth of the state economy which is largely unrelated to the experience of average Californians with respect to health care costs.

Employer-based coverage which includes not only consumer cost sharing and employee share of premium but also employer share of premium is inherently regressive:

- For a family of four making $50,000 with employer coverage, the average premium of $23,000 for family coverage in 2022 equals almost half their income.
- For a family of four making $100,000 a year, the $23,000 still amounts to almost a quarter of family income[1].

Because of this regressivity, even small changes in the rate of growth have a big impact on those with low and moderate incomes.

While many Californians who make less than $50,000 a year rely on public coverage, almost 3 million (48%) have employer coverage. For the 6.3 million Californians under age 65 making between $50,000 and $100,000 a year, almost two-thirds of them or about 4.3 million have employer coverage[2].

Given the inherent regressivity of employer coverage, a measure of ability to afford care and coverage such as median wage or median income better reflects the affordability of care and coverage.

We make this recommendation in the context of worsening affordability for consumers, workers and other purchasers. The cost of private health insurance purchased both for employer and off-exchange individual coverage has grown at a rapid rate over the last decade. Premiums for small business coverage have climbed by 65% and deductibles for small business coverage in California have escalated by 133% in the decade from 2011 to 2021[3] while family deductibles have quadrupled. Spending on public programs has grown much more slowly.[4] Health Access has heard numerous reports of increases of 17%-25% for large group premiums for 2024. In one case, hospital costs increased to 150% of the costs in the prior year. Whether this is price spiking in advance of the cost targets or the result of real underlying cost increases or a change in case mix is not clear. What is clear is that it is not sustainable, and that health care costs for commercial coverage in California start from a high base. In contrast, per capita spending on Medicare has

[1] California Employer Health Benefits: Cost Burden on Workers Varies — 2023 Edition - California Health Care Foundation (chcf.org); Forthcoming study, UC Berkeley Labor Center.
[2] Forthcoming study, UC Berkeley Labor Center.
[3] HCAI PowerPoint Template Reduced Footer Size (Widescreen) April 2023: slide 14.
[4] CBO's Projections of Federal Health Care Spending. We note that Medi-Cal spending has increased in part because of the welcome expansion of coverage under the ACA as well as increases in nursing home costs and in-home supportive services.

leveled off since the enactment of the ACA.[5] Medicare spending grew 6.6% from 1987 to 2005 but only 3.1% from 2006 to 2012 and even more slowly, 2.2%, from 2013 to 2019, according to CBO. At the national level, Medicaid per capita spending has also levelled off.

If California had a unified public financing system based on a system of progressive taxation that taxed both wealth and most sources of income, both earned and unearned, then a measure of the state's economic wealth would be the appropriate economic indicator on which to base the spending target. But the cost of care and coverage for employer coverage is largely delinked from the wealth of the economy: indeed, the California economy, with all its ups and downs, has grown while the affordability of health care offered through employers and unsubsidized individual coverage has diminished.

Instead of a progressively financed universal coverage system, California has a hybrid system of employer coverage, individual coverage which is now a mix of subsidized and unsubsidized coverage as well as Medicare and Medi-Cal.[6] In 2022, employer and household spending amounted to an astonishing $222 billion while the state and local share of Medi-Cal was only $45 billion, out of $472 billion total spending.[7] When looking only at employer and household spending and the state/local share of Medi-Cal, the share is roughly 80%/20%. Federal spending amounted to $208 billion, including both Medicare and the federal share of Medi-Cal but state cost growth targets do not control Medicare spending.

Health Access Recommends:

First, Health Access strongly supports the use of median wages or median income as the sole economic indicator because it reflects the ability of consumers to afford care coverage.

Second, recognizing that the state and local share of Medi-Cal is funded from broad-based taxes, we would not oppose an approach that used an 80/20 split with 80% of the cost growth target based on median wages or median income to reflect

[5] A Huge Threat to the U.S. Budget Has Receded. And No One Is Sure Why. - The New York Times (nytimes.com); CBO's Projections of Federal Health Care Spending. We note that Medicare spending has increased because of the baby boomers aging into Medicare: the flattening is the flattening of per capita spending, not total spending.
[6] CHCF Almanac: Oct. 2022:
[7] Source: HCFA Nov. 17, 2021, slides 12 and 16: Healthy CA for All November 17 Commission Meeting Slides: . The total reported to HCFA included public health and other health spending not included in "total health care spending": $472 billion is a closer approximation of THCE.

employer and household spending and 20% based on a measure of state domestic product to reflect the ability of state and county governments to fund the state and local share of Medi-Cal.

Third, Health Access strongly opposes exclusive or primary reliance on some version of state gross domestic product because the wealth of the California economy is largely unrelated to the ability of most Californians. The use of state GDP will only perpetuate the regressive and inequitable burden on cost health care growth, particularly for low and middle income Californians.

Population Indicators

The enabling statute requires consideration of population indicators, which may include changes in demographic factors, such as aging. Our comments here are the beginning of our input on this question.

The aging of the population is a major consideration for policymakers dealing with the state budget because Medi-Cal is responsible for much of long term care. Conversely, in commercial coverage, long term care is a limited benefit with infinitesimally small costs. Medicare covers short-term, rehabilitative nursing home care but does not include a benefit similar to in-home supportive services. In the context of THCE, aging is a factor but probably not a major one, especially Medicare with its controlled cost growth takes on the responsibility of those over age 65.

We look forward to further discussion about population indicators affecting the spending target.

Health Plan Reporting Threshold

The staff has proposed that the health plan reporting threshold be limited to plans with at least 40,000 lives in any combination of market segments. It would be helpful to know if the staff had considered alignment with the HPD reporting requirements. If not, we would ask that this be considered. If the staff chose a different threshold for this purpose, it would be helpful to know the thinking.

Health Access recommendation: We support the staff recommendation but ask consideration of alignment with HPD reporting requirements.

Provider Attribution: Provider Affiliation Registry

As discussed at the August 2023 Board meeting, one of the challenges facing OHCA is attributing spending growth to provider entities. The presentation notes that "California lacks a provider directory that identities PCP affiliation with provider entities." It is our understanding that there are different types of provider directories:

- California law requires each health plan/insurer to maintain a consumer-facing health plan directory of contracting health providers with such basic information as provider name, address, phone number and willingness to accept new patients. Health plans have generally failed to comply with this law and in some instances, have inaccuracy rates as high as 80% of providers listed[8].
- Health information exchange directories that provide EHR/HIT address information for health systems to share patient information electronically.
- Provider affiliation registries of which organizations and providers are affiliated with which health systems or practices: it is our understanding that Massachusetts among other states have developed such a provider affiliation registry.

The provider affiliation registry is used in Massachusetts to help clarify questions of provider attribution and provider affiliation. Such a provider affiliation registry is also helpful in the work of Cost and Market Impact Reviews in Massachusetts. A similar approach would be useful for OHCA to develop.

Health Access recommends: OHCA develop a provider affiliation registry to track which organizations and providers are affiliated with which health systems or practices. OHCA should consider tracking PPO and HMO costs separately.

Like California, other states have a mix of HMOs and PPOs. While ideally every consumer would have a primary care home, this is not currently the case. In addition, to the extent costs are higher or different for those enrolled in PPOs than those enrolled in HMOs, it may be useful to separate reporting based on PPO versus HMOs.

<u>THCE Design Decisions</u>

THCE: Self-Insured Plans

[8] SB 137 Assembly Health Committee Analysis, 2023

Looking ahead to the September 2023 Board discussion on THCE design decisions, Health Access notes that if at all possible, THCE should include total spending across all lines of business by third party payers on behalf of self-insured employers and trust funds.

THCE: Regional Reporting

Health Access recommends: Health Access strongly supports reporting of THCE by "Covered California" regions. While "Covered California" regions is the colloquial phrase, the use of these regions applies to all of the rules for both the individual and small employer markets as well as rate review for the individual, small group and large group market.

Covered California regions are roughly comparable in population (and sometimes square miles) to state-level reporting in other states such as Rhode Island, Oregon and Massachusetts. Reporting only at the state level in a state with 39 million Californians and over 1,000 miles long (and 540 miles wide) would be helpful but not sufficient.

Thank you for your consideration of these comments. Please contact us with any questions.

Sincerely,

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