2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833
hcai.ca.gov

HEALTH CARE AFFORDABILITY BOARD

MEETING MINUTES
Wednesday, August 28, 2024
9:00 am

Members Attending: Secretary Dr. Mark Ghaly, Dr. David Carlisle, Dr. Sandra Hernández, Richard Kronick, Ian Lewis, Elizabeth Mitchell, Dr. Richard Pan, and Don Moulds

Members Absent: None

Presenters: Elizabeth Landsberg, Director, HCAI; Vishaal Pegany, Deputy Director, HCAI; CJ Howard, Assistant Deputy Director, HCAI; Jessica Altman, Executive Director, Covered California; Don Moulds, Chief Health Director, CalPERS; Christopher Whaley, Brown University School of Public Health

Meeting Materials: August 2024 Board Meeting webpage

Agenda Item # 1: Welcome, Call to Order and Roll Call
Chair Secretary, Dr. Mark Ghaly

Chair Ghaly opened the August meeting of California's Health Care Affordability Board. Roll call was taken, and a quorum was established.

Agenda Item # 2: Executive Updates
Elizabeth Landsberg, Director, HCAI; Vishaal Pegany, Deputy Director, HCAI

Director Landsberg provided an overview of the agenda as well as the following Executive Updates:

- Announcement about revisions made to HCAI's public meeting agenda template on how to request translation and interpretation services. This information is now available in Spanish, Korean, Tagalog, Chinese (Simplified and Traditional), and Vietnamese.
- Announcement that today's meeting has simultaneous interpretation in Spanish available.
- Reminder about HCAI's Hospital Bill Complaint Program: flyers are available in English and Spanish for anyone who believes they were wrongly denied financial assistance, were not told about a hospital's financial assistance program, or were sent to collections but need financial assistance.

- Overview of the Healthcare Payments Data Program's (HPD) July report titled "Fee-For-Service Drug Costs in the Commercial Market," which provides data regarding prescription drug coverage, including:
  - The 25 costliest drugs in California in terms of annual statewide spending
    - These accounted for only 3% of the prescriptions, but account for more than 30% of the total costs ($3.9 billion in 2021).
  - The 25 most commonly prescribed drugs
    - The four most frequently prescribed drugs in California in 2021 were COVID vaccines, which had no out-of-pocket cost.
    - The 25 most frequently prescribed drugs accounted for 12% of all prescriptions and 2.3 percent of total costs ($297 million).
  - The 25 drugs with the largest monthly median out-of-pocket cost for consumers
    - There are caps on out-of-pocket costs for prescription drugs which range from $150-$250 in the commercial market due to the state policy limits.
- Findings from OHCA's additional data analysis in the report, including that:
  - Nearly half of the top 25 costliest prescription drugs are biologics. Increasing access to these lower-cost biosimilar or generic biologics is an important strategy to improve affordability.
  - Insulin is a major driver of the cost of drugs. The branded versions of insulin lispro (Humalog) and insulin glargine (Lantus Solostar) are two of the costliest drugs identified in the report.
  - Both of the above points underscore how California's recent investment in developing its own biosimilar insulin through the CalRx program can make prescription drugs more affordable.

Deputy Director Pegany provided the following Executive Updates:

- Announcement that the statewide spending target percentages were added to the California Code of Regulations via a file and print process.
  - While the spending target is enforceable with or without this regulation, it was posted in the California Code of Regulations to make it easier for the public to find and is structured to allow for future targets to follow.
- Update regarding the Total Health Care Expenditures (THCE) Data Submission Guide:
  - Earlier this year, OHCA adopted regulations for THCE data submission by payers and fully integrated delivery systems (FIDS). Based on feedback after the regulations went into effect, minor changes were needed and regulations have been updated effective July 1, 2024, as a change without regulatory effect. This means that the Office of Administrative Law (OAL) agreed the updates were non-substantive and do not change any reporting obligations.
- Update on data submitter progress:
  - The total medical expenses (TME) data submission deadline for calendar year 2022 and 2023 data is September 1st.
  - OHCA has convened a monthly data submitter workgroup of all plans expected to submit commercial and Medicare data.
  - 18 of 18 expected plans registered with OHCA in April of 2024.
  - In July and August, OHCA conducted one-on-one meetings to answer technical questions and facilitate timely submission of the TME data.
  - OHCA has received test files from four plans.

- Update on Notices of Material Change Transactions:
  - Proposed regulatory revisions were discussed at the June 26th Board Meeting, which followed a public comment period.
  - OHCA posted the revised emergency regulations with a formal Advanced Notice of Emergency Regulatory Action to the OHCA website and sent notice over the OHCA Health Care Market Oversight listserv on August 5th.
  - After the five-day notice period, OHCA submitted the emergency regulatory package to OAL on August 13th. OAL received and considered one comment. OAL approved the package on August 22nd and the revisions became effective that same day.
- Reminder about slide formatting: a yellow arrow indicates that OHCA has decision-making authority over that item and a green arrow indicates that OHCA has ultimate decision-making authority over that item.

Discussion and comments from the Board included:

- A member expressed appreciation for addressing language access issues and also inquired whether written documents can be provided regarding the pharmaceutical pricing analysis as well as updates on the opportunities that CalRx is going to provide.
  - The Office stated that they will send a link to the HPD report and some of their findings. There may also be a webinar recording available. They will also consider how to interject the CalRx updates within an upcoming meeting.
- A member congratulated the Office on its excellent work and commented that having Naloxone as CalRx's initial product is a major step forward for California since it is so hard to obtain in the private sector and will save lives. He also commented that many of the drug names listed in the HPD report as the most expensive are not familiar due to him prescribing these drugs but rather due to the heavy television advertising and suggested that this is not a coincidence.
- Chair Ghaly commented that when talking about the progress of CalRx, part of that presentation would be real time disruption of what others are doing because of our planned activities even if they do not come to fruition. Markets will likely respond to certain things California is doing.

Public Comment was held on agenda item 2. One member of the public provided comment.

Agenda Item # 3: Action Consent Item
Chair Secretary, Dr. Mark Ghaly

a) Approval of the June 26, 2024, Meeting Minutes
Chair Ghaly introduced the action item to approve the June meeting minutes.

Board member Ian Lewis motioned to approve, and Board member David Carlisle seconded.

Public Comment was held on agenda item 3. No public comment was made.
Voting members who were present voted to accept. There were 5 ayes, and 2 abstained. The motion passed.

Agenda Item #4: Action Items
CJ Howard, Assistant Deputy Director, HCAI

a) Vote to Appoint Advisory Committee Member
Assistant Deputy Director Howard introduced the action item to vote to appoint a new Advisory Committee member to fill the vacancy left by Yvonne Waggener, who resigned her appointment in May. Her term was set to end on June 30, 2025. She was in the Hospital category, representing a rural hospital district.

- OHCA accepted solicitations for the Hospital category vacancy in June and received 9 submissions of interest. After reviewing the submissions, the Board subcommittee has recommended the appointment of Travis Lakey, the CFO of Mayers Memorial Hospital District in Shasta County.

Board member Sandra Hernandez motioned to approve the appointment of Travis Lakey to the Hospital vacancy. The appointment shall end on June 30, 2025. Board member Richard Pan seconded.

Public Comment was held on agenda item 4. No public comment was made.

All 7 voting members voted to accept. The motion passed.

Agenda Item #5: Informational Items
Vishaal Pegany, Deputy Director, HCAI;CJ Howard, Assistant Deputy Director, HCAI; Jessica Altman, Executive Director, Covered California; Don Moulds, Chief Health Director, CalPERS; Christopher Whaley, Associate Professor, Brown University School of Public Health

5a) Variation in Health Care Spending, Prices, and Premiums Across California
To better understand health care premiums, spending, and price variation across California, Deputy Director Pegany and Assistant Deputy Director Howard presented data that compared California to the rest of the nation and metropolitan areas in California to each other, and then drilled down into how this variation looks in Monterey County.

Discussion and comments from the Board:

- A member asked whether the price and premium increases were adjusted for inflation or if they are the raw number.
  - The Office responded that the numbers were not adjusted for inflation.
- A member asked whether the data on deductibles reflects what individuals actually spent toward their deductible or if it is the deductible outlined by the plan.
  - The Office responded that it is individuals' out-of-pocket obligation per the plan rather than what they actually spent toward their deductible.
- A member acknowledged the profound impact of the Affordable Care Act on the data and projections.
- A member stated that there should likely be an age adjustment for the per capita data as California's average age is slightly younger. He recommended investigating that aspect of the data.
- A member asked whether the Medi-Cal spending includes the long-term care component of Medicaid.

  - The Office confirmed that the Medicaid spend includes the long-term care component.
- The member recommended applying asterisks next to that data, noting that Medicaid includes long-term care while commercial and Medicare data do not.
- A member noted that California's cost of living impacts the cost of labor, cost of utilities, etc. With California's cost of living being approximately 35-40% higher than the national median average, the data should account for that. There is also the issue of California's cost of living varying throughout the state.
  - The Office responded that the per person health care spending measure reported from the Health Care Cost Institute does factor in the market and demographic factors discussed.
- A member commented that the data in slide 43 shows that California has succeeded in lowering utilization significantly compared to other states. This is likely a historic, one-time change with the advent of managed care. However, the slide that precedes it shows that California's prices are the highest in the country.
- A member noted that the entire northern third of the state is not captured in the Core-Based Statistical Areas (CBSAs). Even though that is a low population area, perhaps the City of Redding could be a useful economic indicator that could provide some insight into cost over that entire region of California.
  - The Chair shared that the new Advisory Committee member is from that region and can help represent some of those concerns and opportunities.
- A member shared that on the northern California/rural issue, CalPERS' data transition to GRVU (global relative value units) has helped but it is an issue of scale.
- A member commented that the data regarding the high prices was the most salient piece of the presentation for them and also stated that California has been through more than a decade of flat health care spending as a share of the Gross Domestic Product and is still in this unaffordable space. The Office and Board need to make progress on this.
- A member commented that per capita Medicare spending increased quickly from 2000 to 2010. If adjusted for inflation spending would show almost zero growth for the decade 2010 to 2020. The "Overall" line in slide 38 increases more rapidly than the others because more of the population is moving into Medicare.
- A member asked if one of the titles on slide 39 is correct to say, "Difference from National Median," or is that price growth in regard to the 12% statewide average.
  - The Office responded that this data reflects the overall spending, showing that per person spending went up by 12% faster than the national median.
  - The Chair commented he hears recommendations or requests to look at data in a slightly different way or to change the labeling to be clearer.
- A member commented that this data in many ways underpins the role of OHCA and the reason OHCA exists. The data, and the personal stories shared, compels the Board to discover how to use the available tools to address the extraordinary impact on the consumers in this region.
- A member noted new pricing data available through the Consolidated Appropriations Act (CAA) will provide more granular pricing data. The member's organization is conducting a pilot program to focus on that and may be able to share information in December or January in regard to where the prices are coming from.
- A member expressed concern regarding the future premium increases. There is a 9% estimated average commercial increase this year, and there are members seeing as high as 20-25% increases.

- A member stated that the United States has the highest health care costs of any country, and many parts of our state are paying nearly double those prices. Monterey County is paying two and a half times the U.S. average for inpatient care through the commercial market. These are prices paid by the 17 million Californians who rely on insurance connected to their work. In their opinion, this is a regressive tax on working people in the state.
- A member asked about the overall prices listed on slide 44 and whether those prices include the cut that insurance companies take.
  - The Office responded that these are prices for health care services, which do not include health plan administrative and profits portion.
  - The member clarified that on top of the high prices Californians are paying for inpatient and outpatient care and professional services, they are also paying the insurance companies.
- A member commented that the slide which shows the average growth of premiums and deductibles over time reflects that Californians are paying more money for insurance, yet receiving less coverage. The member asked whether the Office has any calculation of how much the value of coverage would have gone up had the price held steady. The member assumed that if deductibles had not gone up, the insurance premiums would have gone up quite a bit more.
  - The Office responded that they do not have that calculation but can look into it.
- A member stated that they feel it would be helpful for the Board to look at administrative costs and profits.
- A member noted that given the increase in high deductible health plans, it is surprising that slides 31 and 32 do not show a significant increase in deductibles over the past couple of years and wonders about a dampening effect.
  - The Office responded that is something they could explore.
- A member responded that there's been a significant increase of nearly 50% in deductibles from 2013 to 2022.
- A member commented that in addition to plan administrative costs, providers experience increased administrative costs (e.g., prior authorization) and that the typical primary care doctor only spends 28% of their time on clinical work.
- A member stated that approximately 80% of health care dollars is spent on treating chronic conditions. However, increases in deductibles are preventing those with chronic conditions from obtaining necessary care, which leads to higher costs once they eventually get care.

It was noted that public comment for this item will be held during the public comment section following item 5b.

5b) Public Purchaser Perspectives

Executive Director of Covered California, Jessica Altman, provided an overview of Covered California, highlighting that Covered California is one of the largest purchasers of health care in California overall.

Don Moulds, Chief Health Director of the California Public Employees' Retirement System (CalPERS) provided an overview of CalPERS Regional Cost Variation.

Discussion and comments from the Board:

- A member expressed surprise that CalPERS is experiencing the same issues as all other purchasers despite the general impression that large group purchases can bargain for better rates.
- A member expressed concern regarding Jessica Altman's earlier statement that one of the two region-wide plans, which covers Monterey, San Benito, and Santa Cruz, is considering leaving. They asked Jessica Altman if she could imagine a situation where, similar to property insurance, all insurers leave a region due to climate change or other factors if they cannot obtain the profits they want.
  - Jessica Altman reassured that Covered California would never allow any region to go without a health plan option. However, what it may take to achieve that can become increasingly difficult. Covered California has not yet been put in a position to need to negotiate to keep the plan providers.
- A member expressed gratitude to Jessica Altman for presenting clear and compelling data, as well as for dispelling the myth that this is a health status issue and confirming that it is not a sicker population that is driving the cost of health plans in this region.
- A member stated that an important takeaway from Don Moulds' presentation was that Monterey prices are driving premium increases for the entire state.
- A member asked Don Moulds what CalPERS is considering in terms of consolidation regarding the strategy of changing the site of care. They further inquired about the equal and opposite reaction to the attempt at moving procedures out of hospitals and how feasible that may be as more practices or providers become acquired.
  - Don Moulds advised that they do typically look to move procedures out of hospitals, but in some instances there is good competition for services in a hospital setting, so there needs to be good competition in the new location. Initiatives like reference pricing work best in places like Los Angeles, where there is strong competition, lower prices, and more opportunity to find low-cost, high-quality places to provide services. The other challenge is the complicated relations between hospitals and professional services. Typically, those who are providing the professional services are medical groups that are affiliated with hospitals.
- A member asked Don Moulds if CalPERS is forecasting what some of the innovations and tools might become as the state tries to move services out of hospitals and whether those innovations have any significant promise.
  - Don Moulds stated that the reason CalPERS has three regions on their local entity side is that their local purchasers are more price sensitive than the State of California and they compete for their business. If they go into Los Angeles and offer Northern California prices, nobody will buy their product. CalPERS is committed to comprehensive benefits and does not have any high deductible plans. Considering that the contribution increases will be coming from the individuals, CalPERS is sensitive to the price.
  - Jessica Altman seconded that the market is incredibly price sensitive and how that plays out is quite complicated, as it has much to do with how their financial assistance works. There is a lot of innovation in that space. There are important federal discussions taking place regarding site neutral payments that would cause ripple effects. There have been several examples of where that has been successful, but not scalable, as it is largely dependent on the relationships, the providers in a region, and the dynamics. COVID pushed telehealth to scale faster than anything before in health

care because there was no other choice. Now we must ensure that telehealth is utilized where it is most effective. The challenge is in utilizing these strategies to move people to lower cost locations in a systemic way.
  - Don Moulds expressed that he does not believe CalPERS is doing anything innovative regarding allowing treatments outside of hospitals. They are trying to move surgeries outside of hospitals, if they can be done in ambulatory settings. They don't ever want to see imaging done in a hospital. They are leaning into the interventions that prevent readmission. Medicare plans have taken their direction from many of the optional services that the Centers for Medicare and Medicaid Services (CMS) is now allowing for, such as transportation to preventative care, nutritional meals post discharge, and retrofitting of homes, all of which can prevent falls and readmission. In 2025, CalPERS is moving to a new construct for PPO, including a population health management firm called Included Health, which will be reaching out to their members with complex health conditions and working with them to ensure they receive timely care and necessary secondary services.
- A member recalled that Jessica Altman mentioned bill charge-based contracts, and recommended that the Board prioritize considering a policy tool that looks at how to deter and target bill charge-based contracts.
- A member was troubled by the double-digit annual rate increase in Region Nine and was surprised by the 7.9% average rate of increase over the period of Covered California. They inquired whether CalPERS has a similar increase over a long period of time.
  - Don Moulds advised that he does not have that data readily available; however, they have seen significantly higher annual increases since 2021. They were in the 4-6% range for several years going into 2020 and have seen closer to double-digit rate increases over the last few years.
- Jessica Altman highlighted a few things that are unique to Covered California:
  - The idea of a marketplace was brand new in 2014 and there were adjustments to be priced correctly across the country, although California did a better job than many states in terms of pricing accurately. However, they had generally priced for a healthier population than that which is in the marketplace.
  - Federal policy decisions: The Trump administration's decision to pull federal funding from a program that lowers out-of-pocket costs, which resulted in the funding for that program being built into premiums, causing a large increase in premiums that year, that was irrelevant to the underlying health care costs in the state.
  - Over the last five years, Covered California averaged a 5% increase annually, which does include some COVID years with very low increases.
- A member expressed appreciation for both presentations, but particularly with Don Moulds' presentation, which highlighted how Monterey's experience ripples across the state. The targeted focus may say something about the broader opportunity.
- A member asked what role variation in utilization plays into the costs, specifically for Monterey. It was stated that the people in Monterey are no sicker, yet their prices are higher.
  - Jessica Altman responded that they did not have that data, but would research further. She was most shocked to learn California is the lowest on utilization, yet the highest on prices. If health care costs less, people will utilize it more. While she doesn't have data on utilization, she would be surprised if they complete the analysis and find that risk score is 15% lower in Monterey but the inpatient utilization is much higher.

- A member asked Don Moulds to elaborate on the contrast between the hospital outpatient costs on slide 79 and the professional services costs on slides 80 and 81. They further inquired whether the physicians and others in the outpatient sector are truly not driving up costs in Monterey relative to hospital outpatient services.
  - Don Moulds confirmed that physicians and others in the outpatient sector are not driving up costs in Monterey relative to hospital outpatient services.
- A member asked how to handle costs in less densely populated areas with fewer providers/facilities available. For example, there may be only one hospital within 100 miles that does not have high utilization.
  - Jessica Altman responded that for rural hospitals, there needs to be a different discussion about what it takes to keep a hospital open, what services are necessary, how to get people where they need to go in a way that's timely and supportive. Potential resolutions include unique payment models or other ways of looking at hospital financing.
  - Don Moulds advised that CalPERS tried to make HMOs available in every county in California so that people have that choice. HMOs do a better job of delivering integrated care and have lower out-of-pocket costs. Unfortunately, it's going to be more expensive to deliver care in rural areas.
- A member expressed pride in having authored legislation to increase subsidies for Covered California to help address affordability.
- A member recommended that the Board review the injunctive relief provisions from the Sutter case on anticompetitive practices, which could be informative.
- A member commented on the striking difference between the opportunities in the northern and southern parts of Monterey County, with the north appearing to have more opportunities. They believe this is due to the ability to build an adequate network with providers outside of the borders of the county more effectively in the Northern part of this county than those located in the middle or south.
  - Jessica Altman agreed and used Kaiser's expansion as an example, sharing that Kaiser is anchored through hospitals out of Santa Cruz and is able to come into the northern part of Monterey. Without Monterey hospitals, an adequate network cannot be provided in the southern part of the region. The Department of Managed Health Care (DMHC) oversees network adequacy and approves exceptions to recognize some of the unique dynamics. However, there are also times when an ER is needed in a community.

Public Comment was held on agenda item 5b. 32 members of the public provided comments.

5c) Case Study: Monterey County Hospitals and State Options to Address High Costs

Deputy Director Pegany and Assistant Deputy Director Howard presented a case study on hospitals in Monterey County and state options to address high costs. OHCA staff used publicly available HCAI data to develop a case study analysis of the hospitals in Monterey, including patient profiles and price, financial, and wage metrics. Following this study, Deputy Director Pegany introduced Dr. Christopher Whaley, who provided an examination of Monterey County hospital prices and potential state options.

Discussion and comments from the Board:

- A member asked Dr. Christopher Whaley if he knows more about the anti-competitive contract provisions that Texas put in place and how those work.
    - Dr. Whaley stated that he is not an expert in Texas legal policy, but believes, their model was based off the Sutter case and designed to prevent those same practices.
- A member commented that their organization had some involvement in that anti-competitive contract and confirmed that it was based off the Sutter case provisions of no all-or-nothing contracting, no prohibitions on tiering; they believe this is a great roadmap for policy.
- A member stated that, the evidence shows every hospital should be able to be financially healthy at 160% of Medicare max, and there are no rational cost inputs on commercial pricing, unlike Medicare pricing where they account for wages and regionality. It is a matter of efficiency and effective management, which is why there is consistent performance. It underscores why cost shifting is not the issue. The member then asked the presenter what is considered a reasonable price – where the evidence shows that all hospitals should be able to succeed financially.
    - Dr. Whaley responded that if you take the hospital reported losses on Medicare and Medicaid as a given, add those up and then compare that to what a privately insured patient would have to pay for the hospital, and add in a little bit of a margin, the results would be roughly 150% or 200% of what Medicare pays. For example, the evidence in Michigan where commercial insurers are paying hospital prices that are roughly 180% of what Medicare pays, an individual could still go to the hospital in Ann Arbor or elsewhere in Michigan, but the purchasers and employers in Michigan know that hospital care and health care prices come out of worker paychecks, and are very proactive in making sure that the costs do not spiral out of control. That seems to be the price range that would still provide access to care.
- A member thanked the presenter for putting the payer mix story to bed and asked if, under a 3.5% spending target that is phasing down to 3%, could the hospitals theoretically meet that spending target on their prices and still generate profit margins 3-4+ times that of current profits compared to the rest of the state.
    - Dr. Whaley responded that if the manageable price were to be in the 200% of Medicare range and the hospitals here were charging 500% or 4 to 5 times Medicare, then yes, the spending target could drop down and still result in a healthy profit margin.
    - The member then asked if it is a fair takeaway, given what was said about market power, to say that the hospitals could comply with the spending target, and it should not be assumed that the hospitals would pass on the equivalent amount to purchasers; they are still able to command the prices given the market.
    - Dr. Whaley affirmed and added that economists worry about if an agent or provider with lots of market power is able to use that power to extract high prices, then if they were able to limit the impacts of that market power-based extraction, the business can still perform.
- A member commented that in the neighboring county of San Benito, there is a hospital that has been losing money or struggling to break even, and likely others nearby in a similar situation. The member believed that global budgets would be one approach to solving both problems of outlier costs and of hospitals being unable to pay their bills. The member inquired if Dr. Whaley has looked at other global budget models and how those would relate to the price caps that have been described in Oregon.

  - Dr. Whaley stated that if there were global budgets, or some sort of cap on prices for highly concentrated hospitals or hospitals with outlier prices, used to support the hospitals who are struggling, he believes that would be beneficial to all of those providers, as well as to the communities that rely on those providers and tend to be more socially, medically, and economically vulnerable.
- A member inquired where the money has gone after several years of 9 to 10+ percent operating margins.
  - The Office responded that they suspect it would be in reserves, and nonprofit hospitals invest that back into their system. This is something that the Board can circle back to.
- A member asked why the average revenue margins in California hospitals are more than 2% less than the national average, despite higher prices.
  - Dr. Whaley responded that they have not looked specifically at why the margins are different, but if, for example, medical rates were lower and prices were higher, that is not necessarily evidence of cost shifting. The two are still compatible.
- Another member suggested one reason the margins would be different is that expenses are different; it's more expensive in California. However, clarification is needed because the operating margin data that Dr. Whaley showed from the CMS cost reports is quite different from the operating margin data that Assistant Deputy Director Howard showed from the California annual financial disclosure reports. The HCAI data shows operating margins averaging roughly 3% in California while the data that Dr. Whaley shared showed 11%. It would be useful to have a better understanding of what accounts for the difference. In addition, it would be useful to understand what accounts for the higher costs at the Community Hospital of the Monterey Peninsula (CHOMP) than the statewide average.
  - Dr. Whaley responded that costs are endogenous and could allow entities to be less cost conscious.
- A member asked what costs are higher for hospitals, such as administrative staff, more nursing staff, or differences in wages.
  - Dr. Whaley responded that it is likely a combination of several things across the board, including administrative load, hiring, and facility expenses.
- A member stated that one area that is not a cause of an increase in costs is health care professionals such as physicians, because the expenses for those professionals are lower than they are for the state.
- A member shared that industry standards and regulations, nurse staffing ratios, and seismic safety standards can all drive up costs and asked what the Board should take into consideration in terms of attenuating health care cost increases.
  - Dr. Whaley responded that even with the unique features of the California environment that impact costs, Monterey hospitals are a pricing outlier. It is known that health care spending is driven by market power and market concentration. He recommended further investigation into the larger provider systems in California, specifically what impacts their market structure and how it is used to get higher prices.
  - A member responded that this implies California could be more aggressive in terms of rate setting.
- A member referenced the 200% cap for state employee benefits in Oregon and asked how plausible it may be for a large public purchaser to set such a cap unilaterally.
  - Dr. Whaley replied that Oregon is an innovator. He has seen this also happen in Montana, but that is likely the most different environment compared to California.

Oregon implemented their policy in 2019 or 2020, and this seems to be a model that more and more states are interested in. In Montana, this was achieved through the plan benefit design, and the negotiations in Oregon were achieved by statute.

- A member shared that Washington state also has a policy for state employees where they are attempting to limit the amount the state employees' plans are paying as a percent of Medicare.
    - Dr. Whaley stated that Washington is in progress, and he believes that Nevada is as well. North Carolina attempted to do this as well but was not successful.
- A member advised that there are some private employer members in Florida, which was the one state worse than California, who will not sign a contract over 200% of Medicare unless they can justify it. If the hospital were to come forward with compelling data, then they would consider it, but otherwise it is capped at 200%, so they are accomplishing this through contracting. Another item that could be explored through contracting is site neutral payments.
- A member asked Dr. Whaley if he has conducted any studies on board governance or leadership.
    - Dr. Whaley responded that he has not conducted such studies, but other studies have found that when hospital boards are comprised of, or have members of, large employers that are presumably negotiating those prices, it seems to complicate those negotiations and result in higher prices.

5d) Office of Health Care Affordability Statutory Authority to Address High Costs
Deputy Director Pegany and Assistant Deputy Director Howard provided an overview of the tools that are available in the OHCA statute to address high costs.

Discussion and comments from the Board:

- A member asked what kind of opportunities there may be to do something to address the market failures. They believe that setting targets by sector is something that the Board is required to do and should be moving towards.
    - The Office responded that there is flexibility to set the sector targets sooner but some requirements need to be followed. Another option that could be accomplished sooner is an investigation of high prices and costs of health care services in the region and evaluate whether that is related to consolidation and anticompetitive prices or practices, or the presence of a market failure. The Board's role would be primarily investigative with experts that we have brought on to conduct the cost and market impact reviews (CMIR) in the Monterey market. We could also make a referral to the Attorney General's (AG) office of that information.
- A member asked if we need an additional study to do a market review and what information is OHCA lacking.
    - The office responded it would be a deeper dive in terms of market consolidation; we have data on prices but less about competition.
- A member asked if a CMIR is required in advance of a referral to the AG's office.
    - The Office responded that we want a helpful body of data to provide them.
- A member supported moving toward sector targets ahead of the statutory deadlines.
- A member asked if there are certain events that trigger an initiation of a CMIR and if the Board has the authority to proceed in this direction without a trigger event.
    - The Office advised that a CMIR is typically triggered when the Office receives a notice

  - of a proposed merger or acquisition but statute also allows the Office to conduct investigative studies. The Office could decide now to conduct an investigative study on the Monterey market.
- A member recalled that several slides were about the fully integrated delivery system sector, which is primarily Kaiser North and South. They asked whether there has been consideration to include something other than Kaiser in the near future.
  - The Office clarified that they were only reviewing the statute to help the Board understand that there are several steps in the process, and they are still developing the methodology for measuring hospital costs.
- A member stated that the definition of “sector” is fairly broad and allows a lot of flexibility.
- A member supported a speedy market failure analysis and expressed a desire to have a deeper discussion regarding some of the options that are not within the Board’s authority but that the state might pursue regarding global budgets and rate caps.
- A member shared that they would like to know whether any of the public agencies, through their plans, are in negotiation currently or will be in negotiation with some of the hospitals in this market and if so, if that is not a temporal opportunity for some type of intervention.

Chair Ghaly advised that the Board does not have to make a motion and vote to act on the Monterey market analysis. He also expressed a desire for a presentation at the next meeting about what other states are doing legislatively, through their equivalent of the DMHC, and other opportunities to affect contracting.

Agenda Item #6: General Public Comment

Public Comment was held on agenda items 5c, 5d and 6. 34 members of the public provided comments.

Agenda Item #7: Adjournment

Vice Chair Hernandez adjourned the meeting.