OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Health Care Affordability Board Meeting

August 28, 2024

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Welcome, Call to Order, and Roll Call

Agenda

1. **Welcome, Call to Order, and Roll Call**
   Secretary Mark Ghaly, Chair
2. **Executive Updates**
   Elizabeth Landsberg, Director, and Vishaal Pegany, Deputy Director
3. **Action Consent Item**
   Vishaal Pegany
   a) Approval of the June 26, 2024 Meeting Minutes
4. **Action Item**
   CJ Howard, Assistant Deputy Director
   a) Vote to Appoint Advisory Committee Member
5. **Informational Items**
   Vishaal Pegany; CJ Howard; Jessica Altman, Executive Director, Covered California; Don Moulds, Chief Health Director, CalPERS; Christopher Whaley, Brown University School of Public Health; Sheila Tatayon, Assistant Deputy Director
   a) Variation in Health Care Premiums, Spending, and Prices Across California
   b) Public Purchaser Perspectives
   c) Case Study: Monterey County Hospitals and State Options to Address High Costs
   d) Office of Health Care Affordability Statutory Authority to Address High Costs
6. **Public Comment**
7. **Adjournment**

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Executive Updates

Elizabeth Landsberg, Director
Vishaal Pegany, Deputy Director

HCAI Public Meeting Accessibility

- The Department of Health Care Access and Information (HCAI) can provide translation and interpretation services, including document translation, telephonic, virtual or in-person translation, and interpretation services in languages other than English and in American Sign Language.
- To request the written translation of the meeting materials, or for verbal or American Sign Language interpretation at a Board meeting, please contact Megan Brubaker at ohca@hcai.ca.gov at least seven days prior to the meeting.
- HCAI revised its public meeting agenda template to provide information regarding requesting assistance in Spanish, Korean, Tagalog, Chinese (Simplified and Traditional), and Vietnamese.

Hospital Bill Complaint Program

If you believe you were wrongly denied financial assistance for a hospital bill, you may file a complaint with HCAI's Hospital Bill Complaint Program.

If you are uninsured (self-pay) or underinsured (have high medical costs) AND your family income is at or below 400 percent of the federal poverty level, you can get financial assistance for your hospital bill.

File a complaint if:

- You applied for financial assistance but were denied.
- You were never told about the financial assistance program.
- You were sent to collections but need financial assistance.

For more information, visit: http://hospitalbillcomplaintprogram.hcai.ca.gov/

HPD Rx Report

- HCAI recently released its Healthcare Payments Data (HPD): Fee-For-Service Drug Costs in the Commercial Market report, with data on the cost of prescription drugs.
- The report includes data about pharmaceuticals provided by commercial plans in California in 2021, including:
  - The top 25 costliest drug products in terms of total annual statewide spending;
  - The top 25 most frequently prescribed drugs covered by commercial plans; and
  - The top 25 drugs with the largest consumer monthly median out-of-pocket cost.

HPD Rx Report

- The report's key findings include:
  - The 25 costliest drugs account for 3.2 percent of all prescriptions in the commercial market but account for nearly 30 percent of total costs at more than $3.9 billion in 2021.
  - The four most frequent prescriptions in the commercial market in 2021 were COVID-19 vaccines. The 25 most frequent prescriptions account for 12 percent of all prescriptions and 2.3 percent of total costs at $297 million.
  - The monthly median out-of-pocket cost for the 25 prescription drugs with the highest monthly median out-of-pocket cost ranged from $150 to $250 in the commercial insurance market. State policy limits the maximum out-of-pocket cost for the commercial market.

Report Analysis by OHCA

- The Office of Health Care Affordability (OHCA) analyzed the report's data and identified two key points:
  - Almost half of the top 25 costliest prescription drugs are biologics. Increasing access to lower cost biosimilar (i.e., "generic" biologics) versions of these drugs would 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 points underscore how California's recent investment in developing its own biosimilar insulin through the CalRx program can make prescription drugs more affordable.

Spending Target Codified in Regulation

California Code of Regulations Title 22. Social Security
Division 7. Health Planning and Facility Construction
Chapter 11.5. Promotion of Competitive Health Care Markets; Health Care Affordability
Article 2. Health Care Spending Targets

§ 97447. Statewide Spending Target

Effective: June 27, 2024

The Statewide Per Capita Spending Target (target) is set as follows:

(a) For performance years 2025 and 2026, the target is 3.5%.
(b) For performance years 2027 and 2028, the target is 3.2%.
(c) For performance year 2029, the target is 3.0%.

Authority cited: Sections 127501 and 127502, Health and Safety Code.
Reference: Sections 127501 and 127502, Health and Safety Code.

THCE Data Submission Guide Updates as a Change Without Regulatory Effect

California Code of Regulations Title 22. Social Security
Division 7. Health Planning and Facility Construction
Chapter 11.5. Promotion of Competitive Health Care Markets; Health Care Affordability
Article 2. Health Care Spending Targets

§ 97445. Definitions

Effective: July 1, 2024

(s) "THCE **Data Submission Guide**" or the "Guide" means the Office of Health Care Affordability: Total Health Care Expenditures Data Submission Guide (Version 1.1), dated June 2024, and hereby incorporated by reference. The Guide is available on, and may be downloaded from, the Department's website.

(t) "**OHCA Attribution Addendum**" means the Office of Health Care Affordability: Attribution Addendum, dated June 2024, and hereby incorporated by reference. The OHCA Attribution Addendum is available on, and may be downloaded from, the Department's website.

Slide Formatting

Indicates informational items for the Board and decision items for OHCA

Indicates current or future action items for the Board

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Public Comment

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Action Consent Item: Approval of the June 26, 2024 Board Meeting Minutes

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Action Item : Advisory Committee Member Appointment

Advisory Committee Vacancy

- Yvonne Waggener resigned her appointment in May. She was in the Hospital category representing a rural hospital district. Her term was set to end on 6/30/2025.
- Nine submissions were received and considered to fill the vacancy.
- The subcommittee recommends the appointment of Travis Lakey, CFO of Mayers Memorial Hospital District (Shasta County).

Current Advisory Committee Members

Payers

Aliza Arjoyan
Senior Vice President of Provider Partnership and Network Management, Blue Shield of California

Yolanda Richardson,
Chief Executive Officer, San Francisco Health Plan

Andrew See
Senior Vice President, Chief Actuary, Kaiser Foundation Health Plan

Hospitals

Barry Arbuckle
President & Chief Executive Officer, MemorialCare Health System

Tam Ma
Associate Vice President, Health Policy and Regulatory Affairs, University of California Health

Travis Lakey
Chief Financial Officer, Mayers Memorial Hospital District

Medical Groups

Hector Flores
Medical Director, Family Care Specialists Medical Group

Stacey Hrountas
Chief Executive Officer, Sharp Rees-Stealy Medical Centers

David S. Joyner
Chief Executive Officer, Hill Physicians Medical Group

Physicians

Adam Dougherty
Emergency Physician, Vituity

Parker Duncan Diaz
Clinician Lead, Santa Rosa Community Health

Sumana Reddy
President, Acacia Family Medical Group

Purchasers

Ken Stuart
Chairman, California Health Care Coalition

Suzanne Usaj
Senior Director, Total Rewards, The Wonderful Company LLC

Abbie Yant
Executive Director, San Francisco Health Service System

Health Care Workers

Stephanie Cline
Respiratory Therapist, Kaiser

Sarah Soroken
Mental Health Clinician, Solano County Mental Health

Cristina Rodriguez
Physician Assistant, Altura Centers for Health

Consumer Representatives & Advocates

Carolyn J Nava
Senior Systems Change, Disability Action Center

Mike Odeh
Senior Director of Health, Children Now

Kiran Savage-Sangwan
Executive Director, California Pan-Ethnic Health Network (CPEHN)

Rene Williams
Vice President of Operations, United American Indian Involvement

Marielle A. Reataza
Executive Director, National Asian Pacific American Families Against Substance Abuse (NAPAFASA)

Organized Labor

Joan Allen
Government Relations Advocate, SEIU United Healthcare Workers West

Carmen Comsti
Lead Regulatory Policy Specialist, California Nurses Association/National Nurses United

Janice O'Malley
Legislative Advocate, American Federation of State, County and Municipal Employees

Kati Bassler
President, California Federation of Teachers, Salinas Valley

Academics/ Researchers

Stephen Shortell
Professor, UC Berkeley School of Public Health

Red font = new member recommendation and/or category

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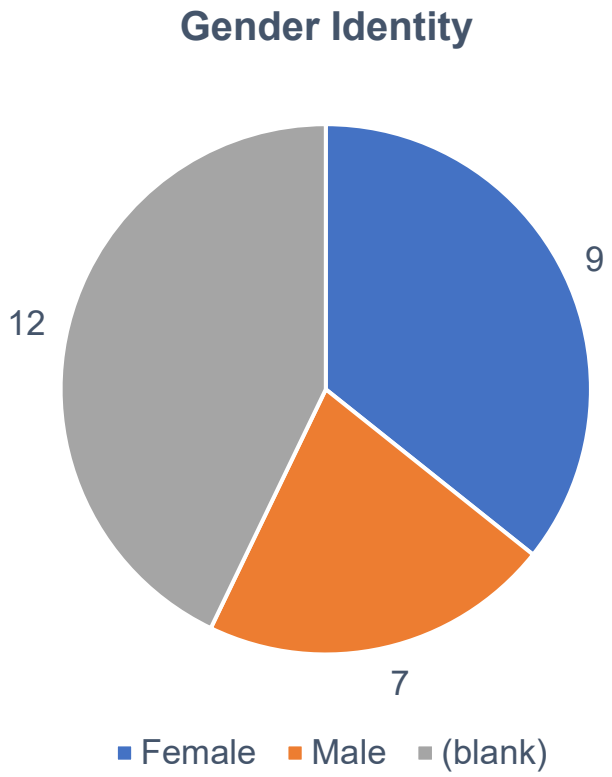
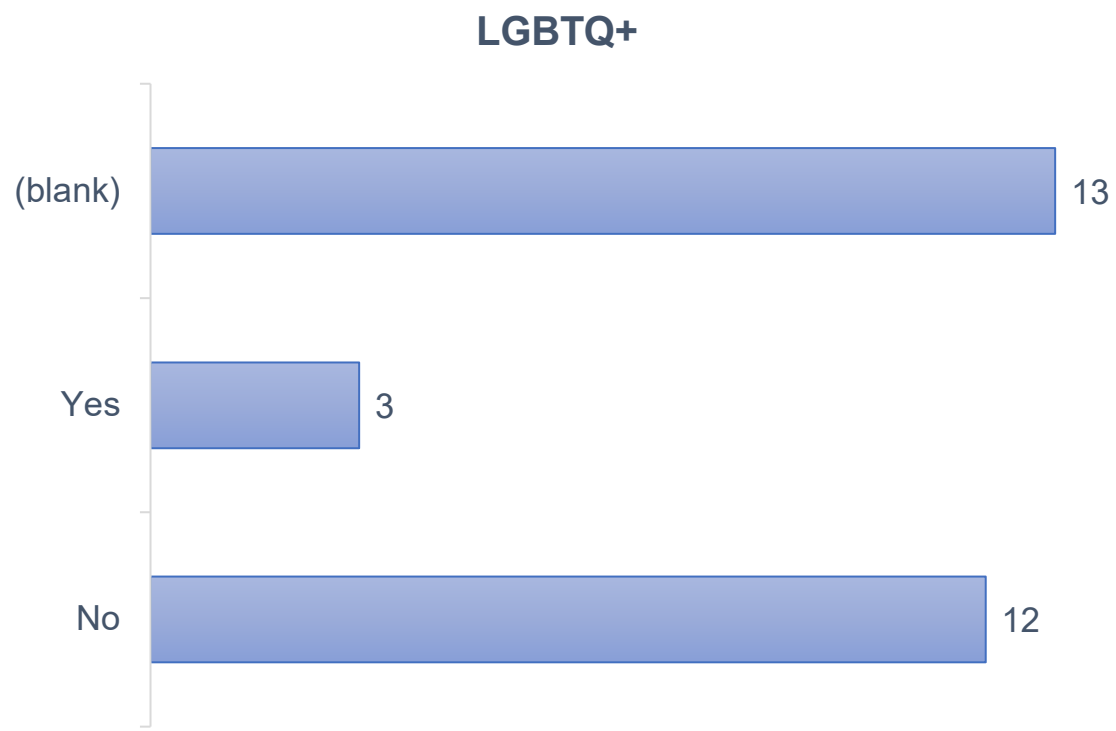
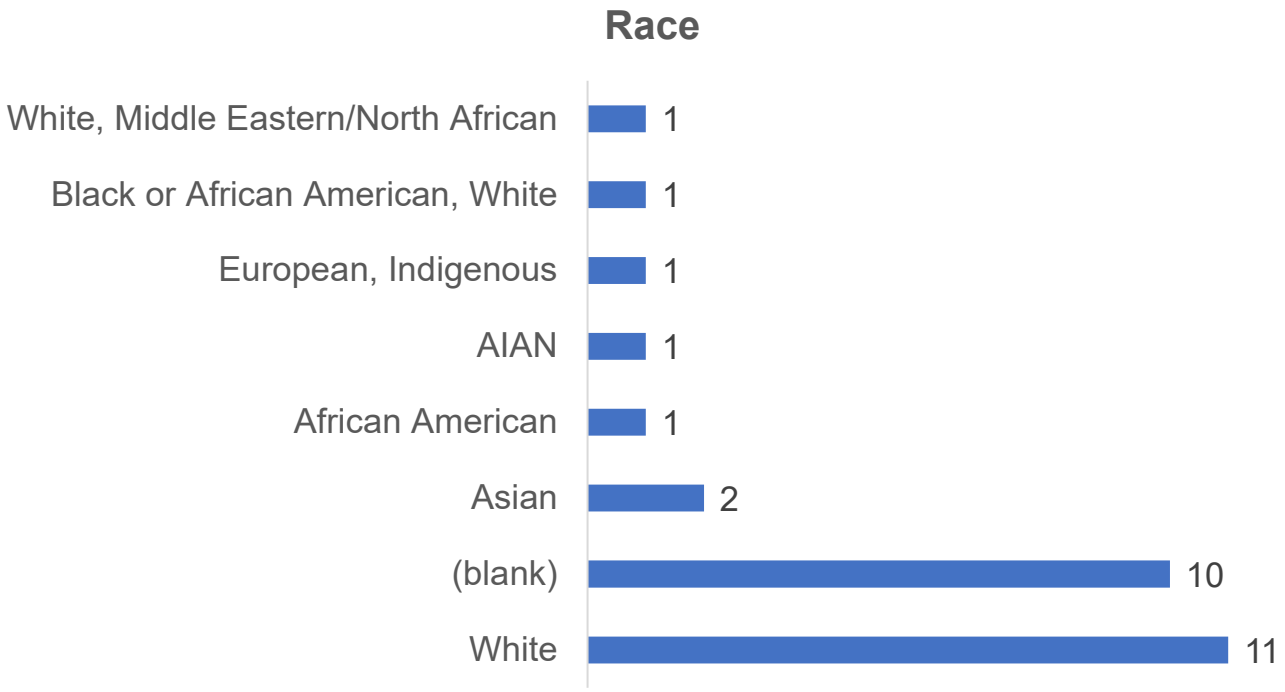
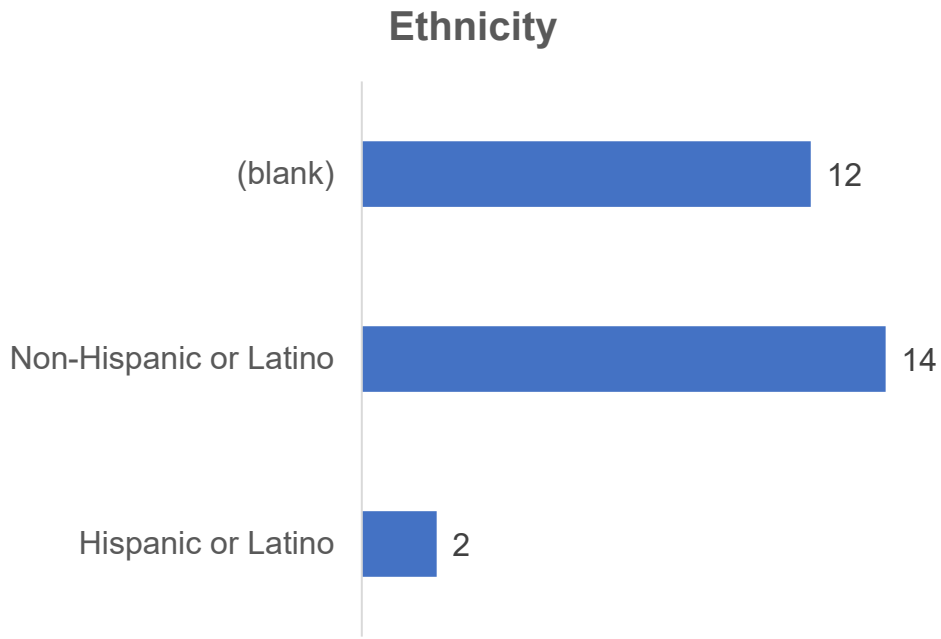
Demographics of Recommended Advisory Committee



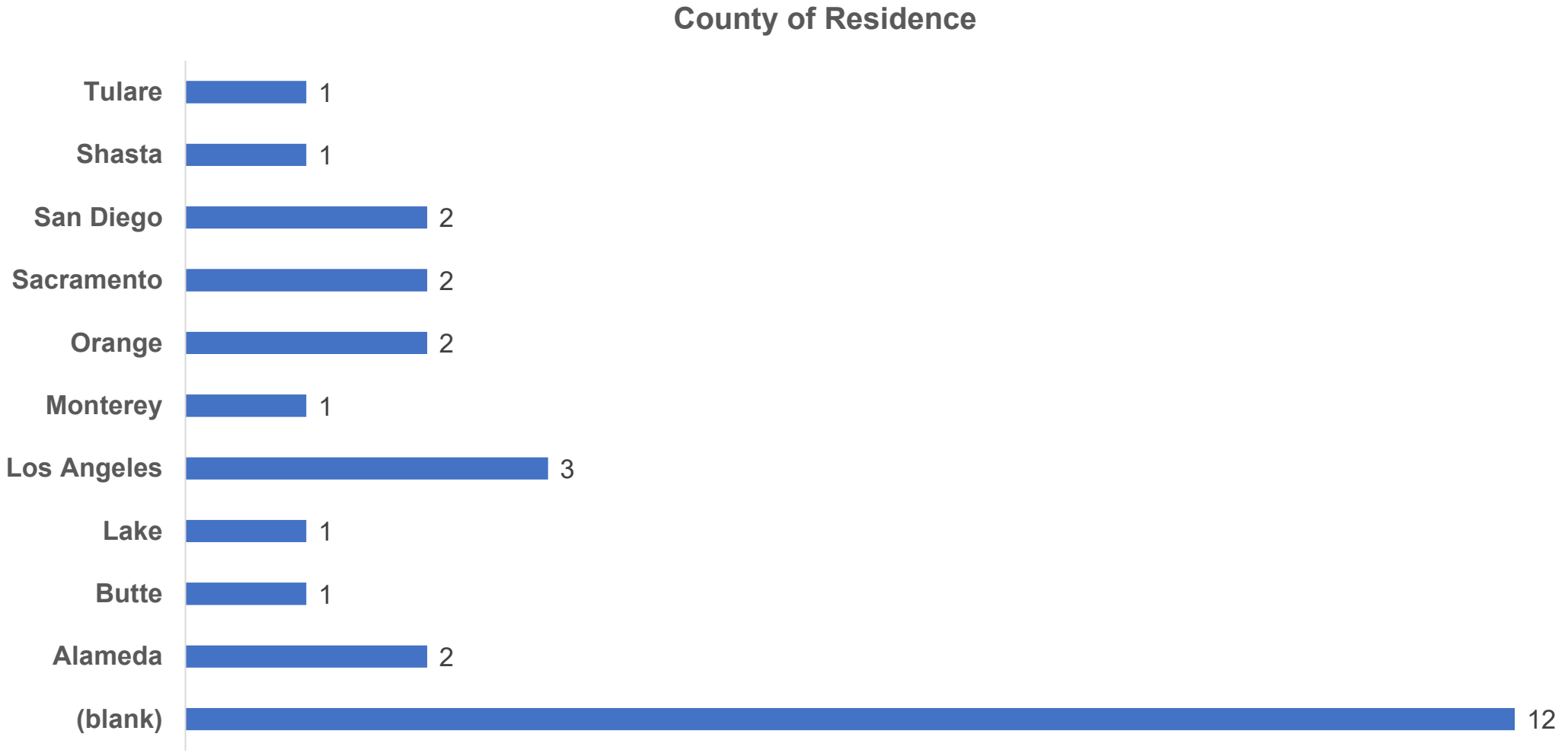


Demographics of Recommended Advisory Committee





Demographics of Recommended Advisory Committee



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Draft Motion

- Approve the appointment of Travis Lakey to the Hospital vacancy.

- The appointment shall end on June 30, 2025.

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Public Comment

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Informational Items

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Variation in Premiums, Spending, and Prices Across California

Vishaal Pegany, Deputy Director
CJ Howard, Assistant Deputy Director

Overview of Data Sources

- In this section, we present publicly available data on health care premiums, spending, and prices. These data sources include:
  - Health Care Cost Institute (HCCI) Healthy Marketplace Index (HMI)
  - California Department of Finance
  - U.S. Bureau of Economic Analysis
  - U.S. Centers for Medicare and Medicaid Services
  - HCAI data sources including Healthcare Utilization - Patient Level Administrative Data and Hospital Annual Financial Data.
- While existing publicly available data can shed light on health care premiums, spending, and prices in California, it does include many gaps. OHCA's charge is to collect more comprehensive data. As we collect and analyze new data, we will share insights with the Board and the public to increase transparency on variation across the state.

Data Source: Healthy Marketplace Index

- The Health Care Cost Institute (HCCI) is an independent non-profit that collects and aggregates employer-sponsored claims data from four health plans: Blue Cross Blue Shield, Kaiser Permanente, Aetna, and Humana.
- HCCI's Healthy Marketplace Index (HMI) project focuses on drivers of local health care spending (price, use and service mix) for major urban areas across the U.S. from 2017-2021.
- Healthy Marketplace Index data for California is available for 13 Core-Based Statistical Areas (CBSA's).
  - A CBSA is an area consisting of a county (or counties) associated with at least one urban core of at least 10,000 people and having a high degree of social and economic integration with the core.

Analytic sample for HMI index metrics contains 4.3 billion claims from 2017-2021 from more than 41 million individuals annually. Total dataset includes 55 million covered lives, over 1 billion claims each year, and covers one-third of the employer-sponsored insurance population. There are approximately 4 million commercially-insured California residents included in the data. Health Care Cost Institute, 2023. See the Technical Appendix for more information.

Definitions

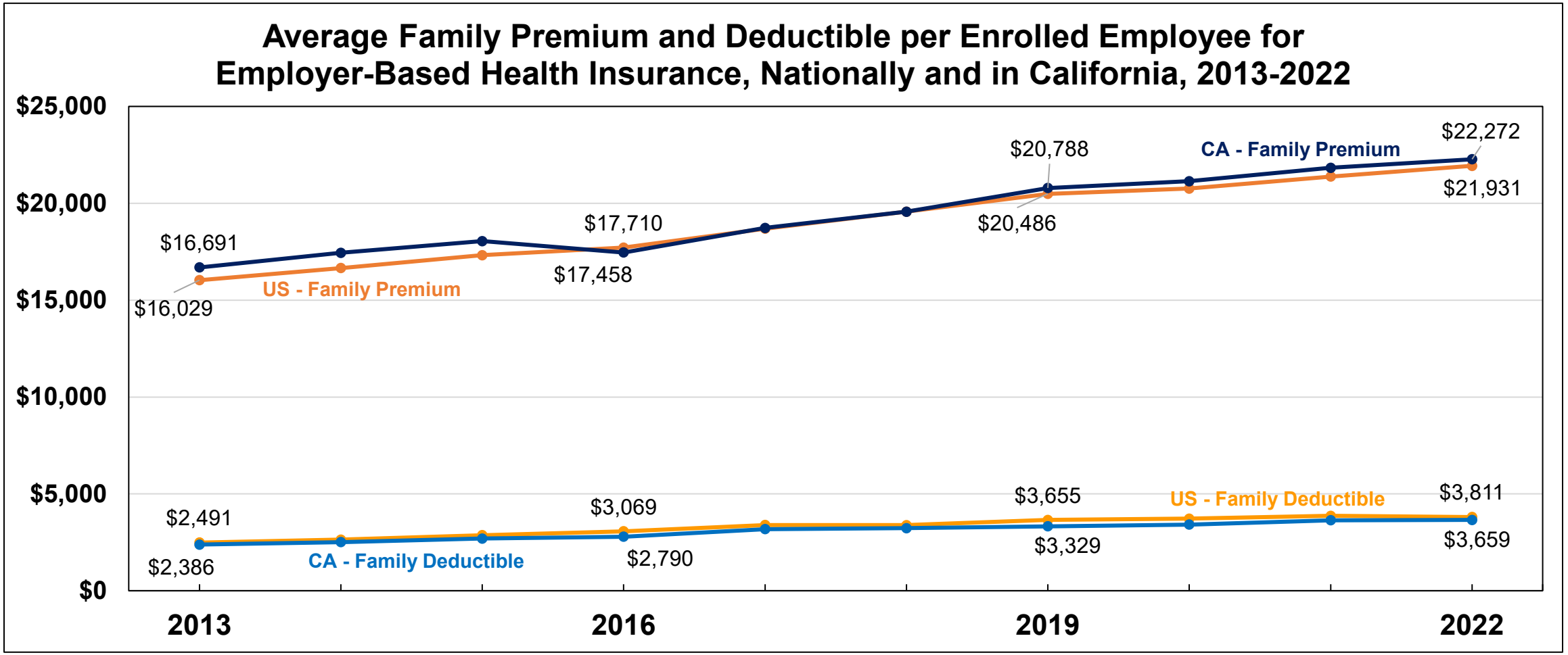
Category	Definition
Premiums	Monthly amount paid by a consumer and/or employer for health insurance.
Spending	Amount spent by or on behalf of consumers on personal health care, which may include hospital care, clinical services, copays, deductibles, and prescription drugs.
Price	Amount a health care entity or provider is paid for a health care service.

Health Care Premiums

Key Takeaways: Health Care Premiums

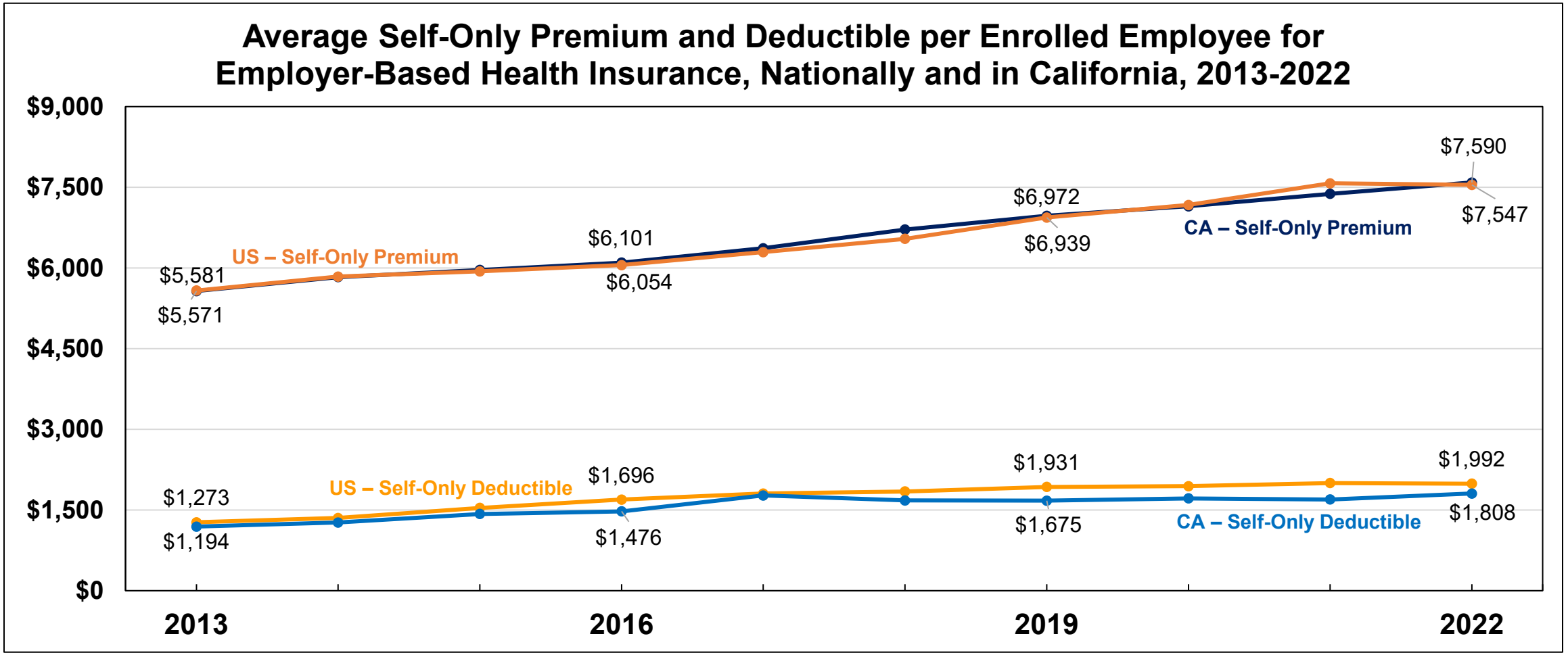
- California self-only and family premium and deductible growth are consistent with national trends for the years between 2013 and 2022.
  - **Trends in Family Insurance:**
    - Nationally, premiums increased by 37% and deductibles increased by 53%.
    - In California, premiums increased by 33% and deductibles increased by 53%.
  - **Trends in Self-Only Insurance:**
    - Nationally, premiums increased by 36% and deductibles increased by 56%.
    - In California, premiums increased by 35% and deductibles increased by 51%.

California Family Premium and Deductible Growth Consistent with National Trends



Note: The Medical Expenditure Panel Survey (MEPS) Insurance Component is an annual survey of establishments that collects information about employer-sponsored health insurance offerings in the United States.
Source: Agency for Healthcare Research and Quality (AHRQ), Center for Financing, Access and Cost Trends. MEPS Insurance Component.
https://meps.ahrq.gov/survey_comp/Insurance.jsp

California Self-Only Premium and Deductible Growth Consistent with National Trends



Note: The Medical Expenditure Panel Survey (MEPS) Insurance Component is an annual survey of establishments that collects information about employer-sponsored health insurance offerings in the United States.
Source: Agency for Healthcare Research and Quality (AHRQ), Center for Financing, Access and Cost Trends. MEPS Insurance Component.
https://meps.ahrq.gov/survey_comp/Insurance.jsp

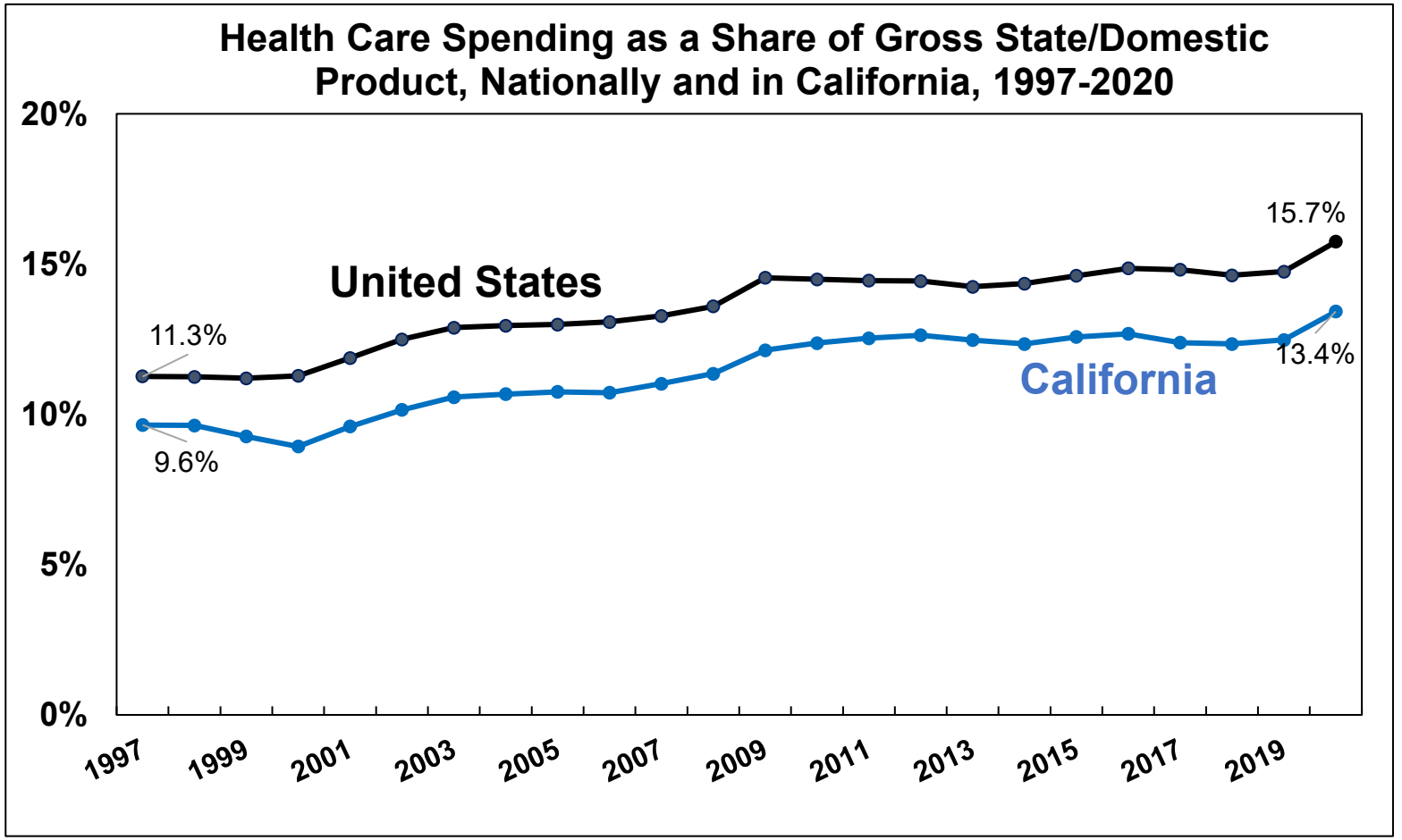
Health Care Spending

Key Takeaways: Health Care Spending

- California health care spending as a share of gross state product shows an upward trend, in line with national levels.
- Per capita personal health care spending in California was above the U.S. average in 2020.
- From 2000-2020, per capita spending in California increased by 5.4% on an annual average basis.
- Overall spending increased for most California metropolitan areas from 2017-2021.

Health Care Spending as a Share of Gross State/Domestic Product, 1997-2020

- Between 1997 and 2020, personal health care spending as a share of gross state product (GSP) grew by 3.8 percentage points, from 9.6% to 13.4%.
- Nationally, personal health care spending as a share of gross domestic product (GDP) grew by 4.4 percentage points, from 11.3% to 15.7%.



Sources: Department of Finance. Gross State Product. https://dof.ca.gov/forecasting/economics/economic-indicators/gross-state-product/; U.S. Bureau of Economic Analysis, Gross Domestic Product, retrieved from FRED, Federal Reserve Bank of St. Louis. https://fred.stlouisfed.org/graph/?id=GDPA

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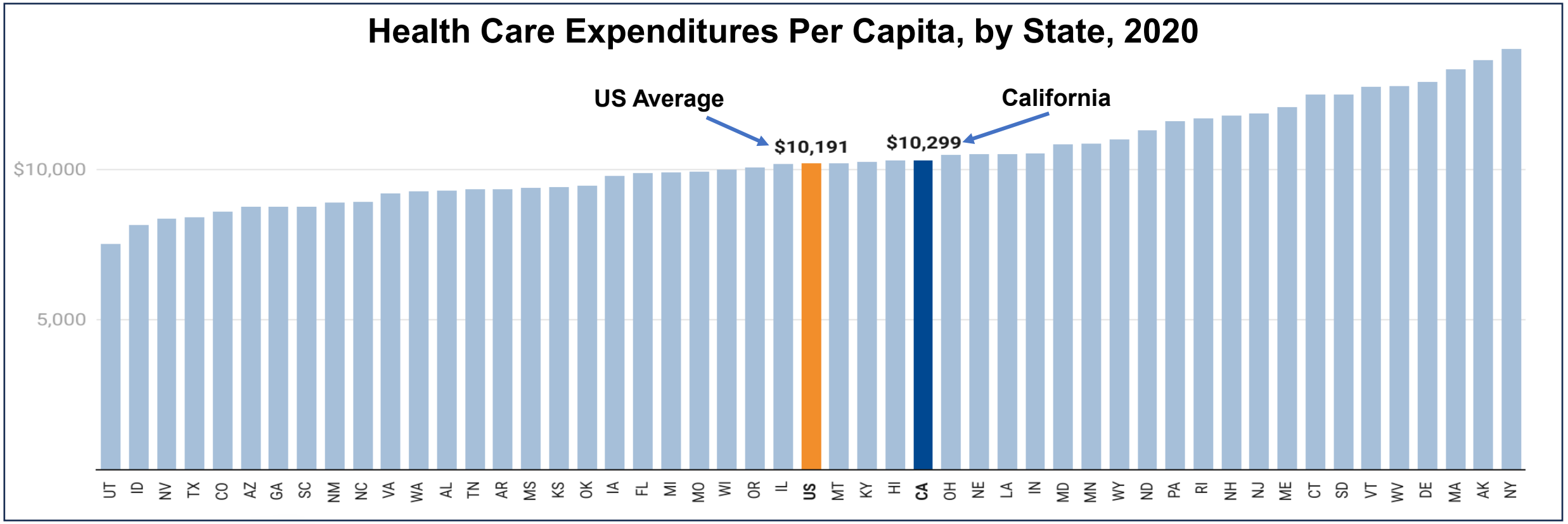
Spending in California Above U.S. Average

In 2020, per capita personal health care spending in California was slightly above the U.S. average.



Source: Centers for Medicare & Medicaid Services. *State Health Expenditure Accounts by State of Residence,1991-2020.* https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/state-residence.

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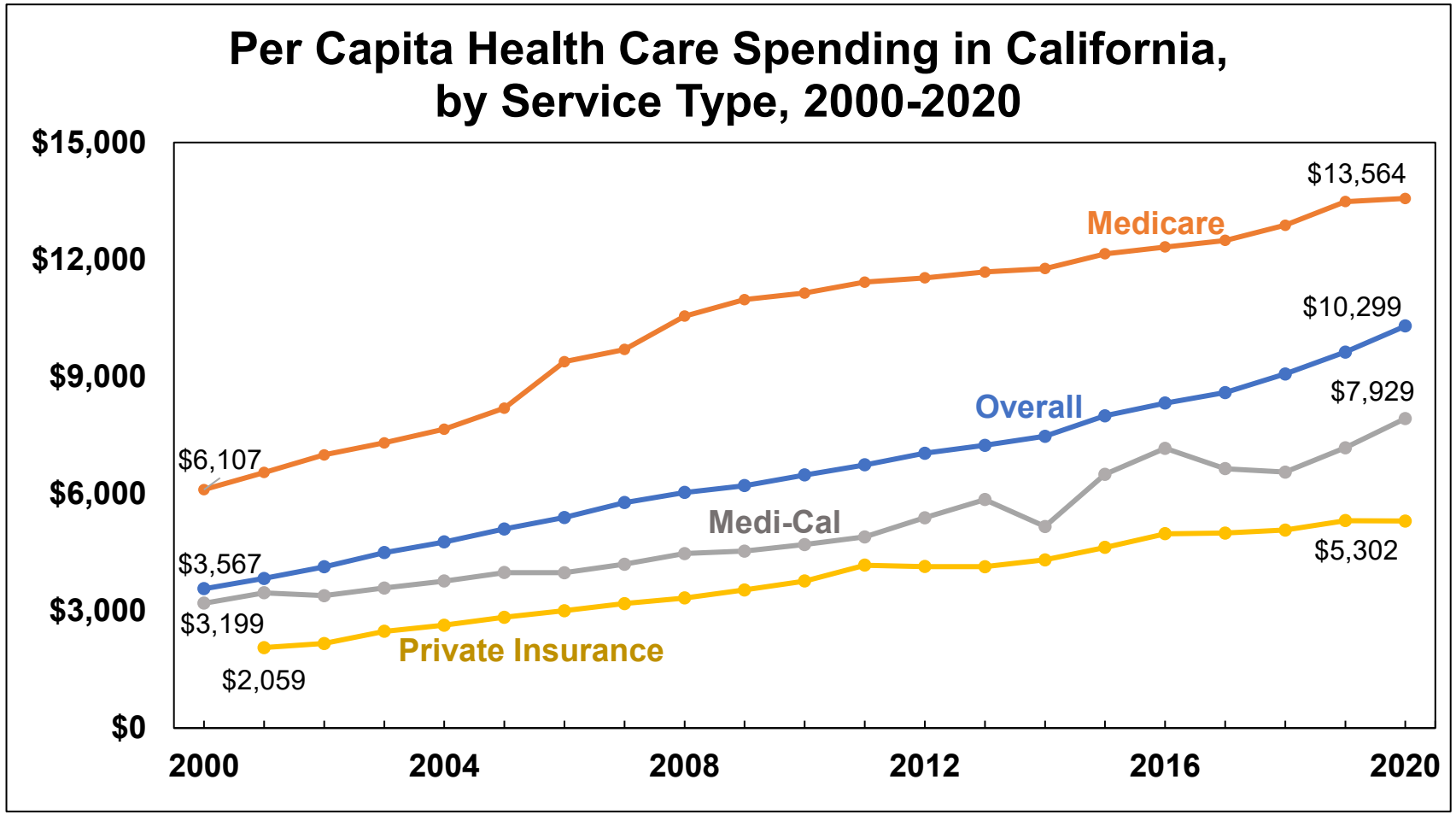
Per Capita Health Care Spending Growth in California

Time horizon	Average change (%) in per capita health spending
5-year change (2015-2020)	**5.2%**
10-year change (2010-2020)	**4.7%**
15-year change (2005-2020)	**4.8%**
20-year change (2000-2020)	**5.4%**

Note: Health care spending refers to personal health care spending, which excludes public health activities, net cost of health insurance, government administration, and investment. Medicaid figures exclude the Children's Health Insurance Program and fully state-funded spending.

Sources: Centers for Medicare & Medicaid Services. *State Health Expenditure Accounts by State of Residence,1991-2020*. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/state-residence; California Health Care Foundation (2023, February). *Health Care Costs 101 Almanac*. https://www.chcf.org/wp-content/uploads/2023/02/PersonalHealthCareSpending2023QRG.pdf

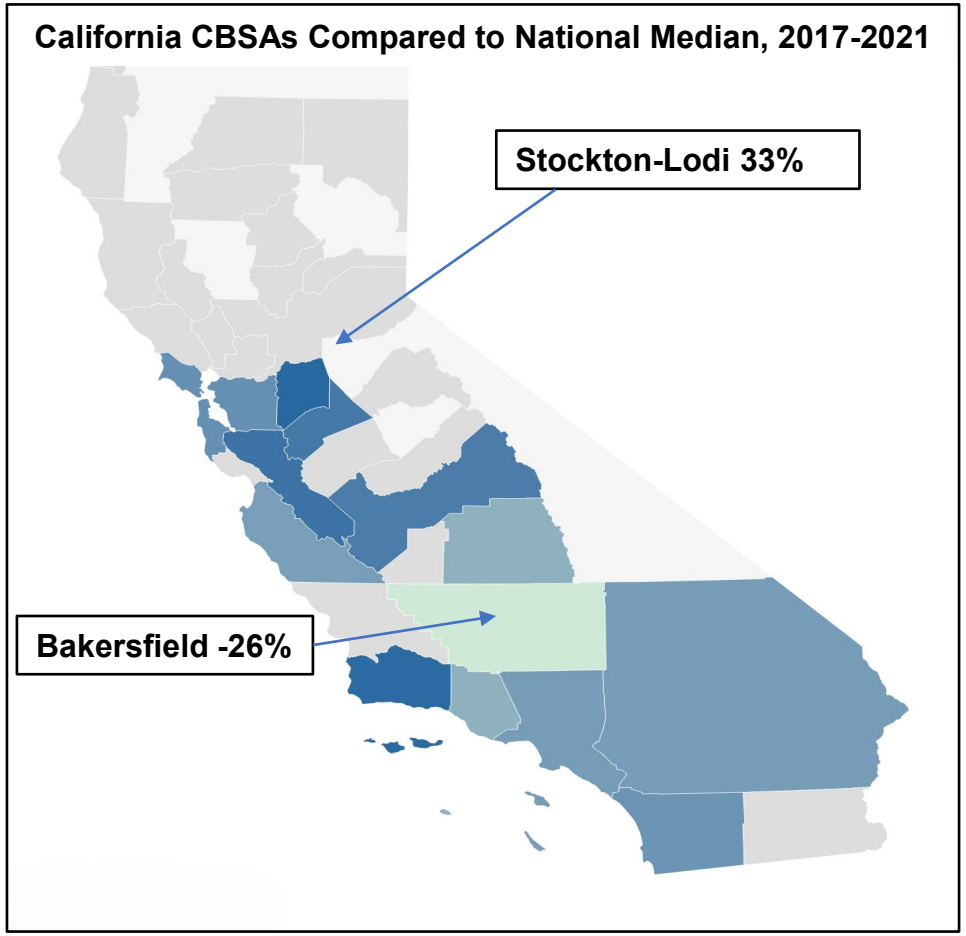
Per Capita Health Care Spending in California, 2000-2020



- From 2000 to 2020, overall per capita health care spending increased by over 5% annually.
- Over that same period:
  - Medicare spending grew annually by 4.1%;
  - Medi-Cal spending grew by 4.6%; and
  - Private health insurance spending grew by 5.1%

Source: Centers for Medicare & Medicaid Services. *State Health Expenditure Accounts by State of Residence,1991-2020*. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/state-residence. Chart courtesy of the California Health Care Foundation.

Overall Spending Increased for Most CA Metropolitan Areas from 2017-2021



Core-Based Statistical Area	Difference from National Median
Stockton-Lodi	33%
Santa Maria-Santa Barbara	32%
San Jose-Sunnyvale-Santa Clara	28%
Modesto	25%
Fresno	23%
San Francisco-Oakland-Hayward	14%
San Diego-Carlsbad	12%
STATEWIDE AVERAGE	12%
Los Angeles-Long Beach-Anaheim	8%
Riverside-San Bernardino-Ontario	8%
Salinas/Monterey	7%
Oxnard-Thousand Oaks-Ventura	-1%
Visalia-Porterville	-1%
Bakersfield	-26%

Note: The gray areas did not meet the criteria for inclusion in the Healthy Marketplace Index (population, coverage and utilization too small or rural to report at a CBSA level). Source: Health Care Cost Institute, *Healthy Marketplace Index, 2017-2021.* https://healthcostinstitute.org/hcci-originals/healthy-marketplace-index/hmi?highlight=WyJoZWFsdGh5IiwibWFya2V0cGxhY2UiXQ==; *Understanding Health Care Spending*, 2021. https://healthcostinstitute.org/hcci-originals/hmi-interactive#HMI-Summary-Report-Spending-Over-Time

Health Care Prices

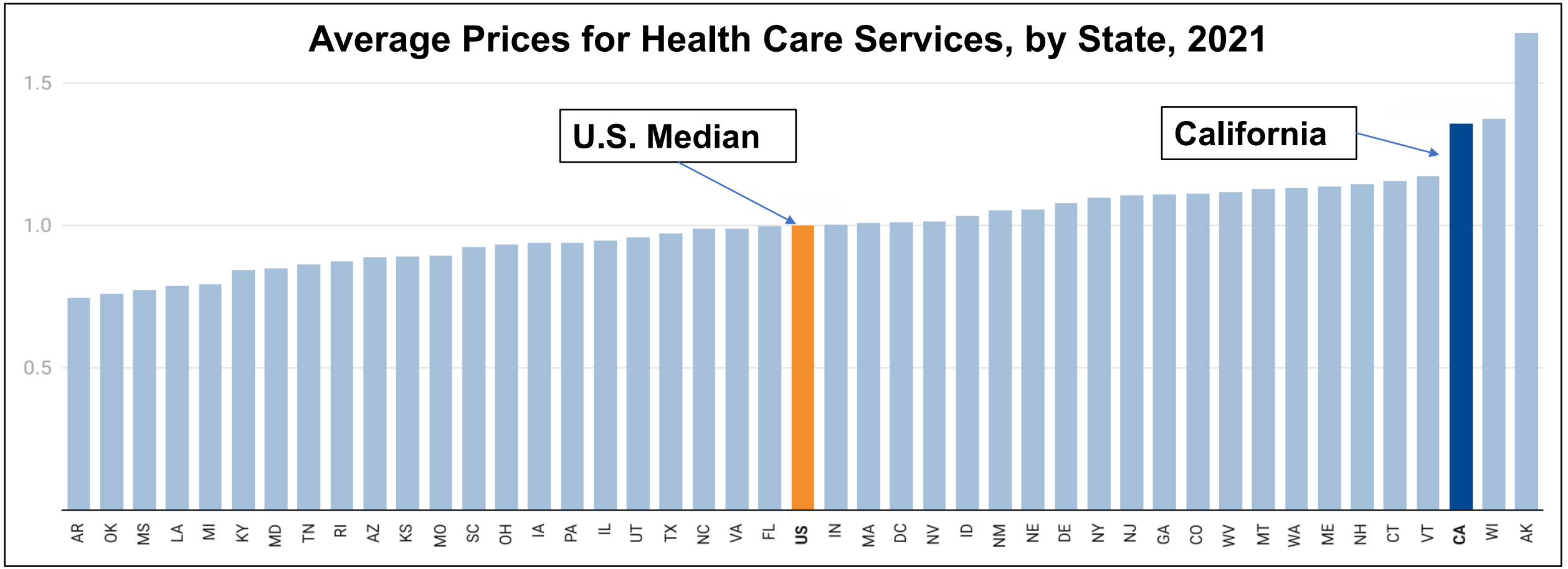
Key Takeaways: Health Care Prices

- Average prices paid for health care services in California were the third highest average, compared to other states in 2021.
- California had the lowest average utilization among U.S. states in 2021.
- Average prices paid for overall, inpatient, outpatient and professional health care services exceeded the national median for most California metropolitan areas in 2021.
- Most California metropolitan areas paid for double-digit price increases from 2017-2021.

Source: Health Care Cost Institute. *Healthy Marketplace Index, 2017-2021.* https://healthcostinstitute.org/hcci-originals/healthy-marketplace-index/hmi.

Prices in California Among the Highest

When comparing average prices for health care services, California had the third highest average among U.S. states in 2021.



Source: Health Care Cost Institute. *Healthy Marketplace Index, 2017-2021.* https://healthcostinstitute.org/hcci-originals/healthy-marketplace-index/hmi.

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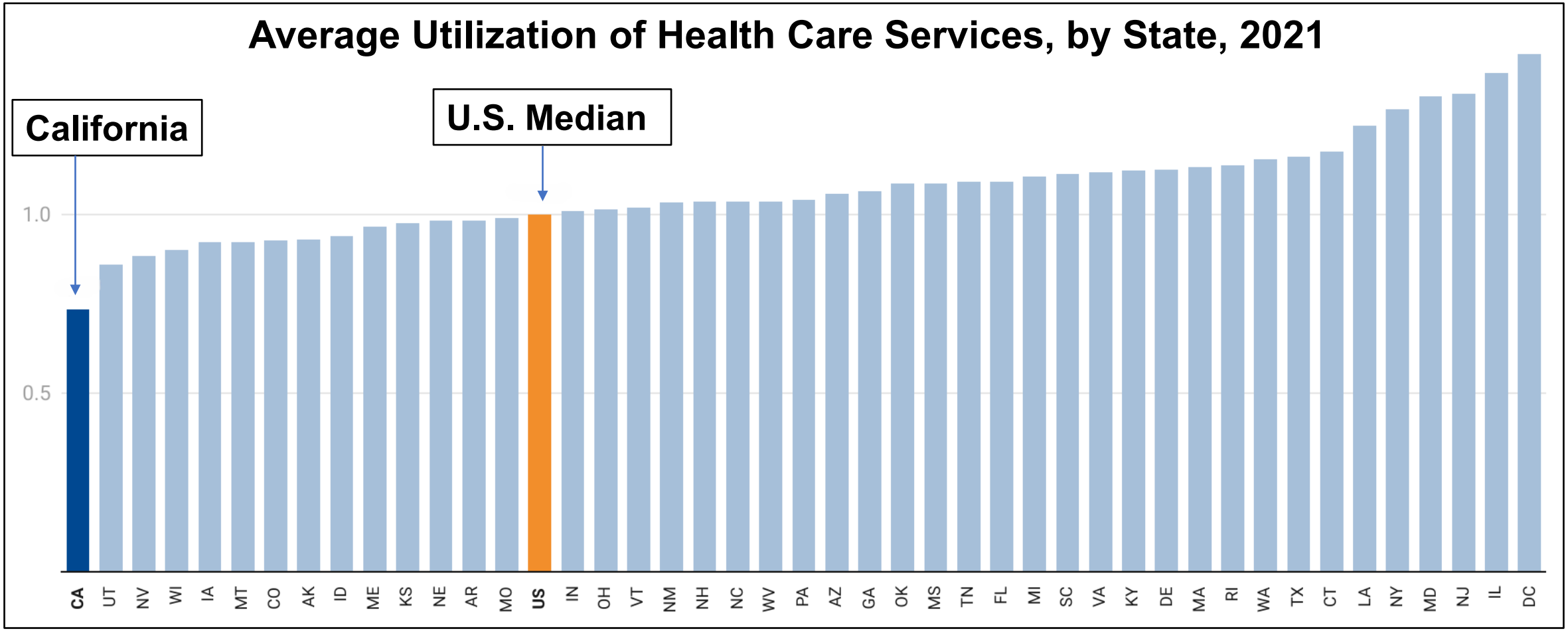
Utilization in California is the Lowest

When comparing utilization, California had the lowest average among U.S. states in 2021.



Source: Health Care Cost Institute. *Healthy Marketplace Index, 2017-2021.* https://healthcostinstitute.org/hcci-originals/healthy-marketplace-index/hmi.

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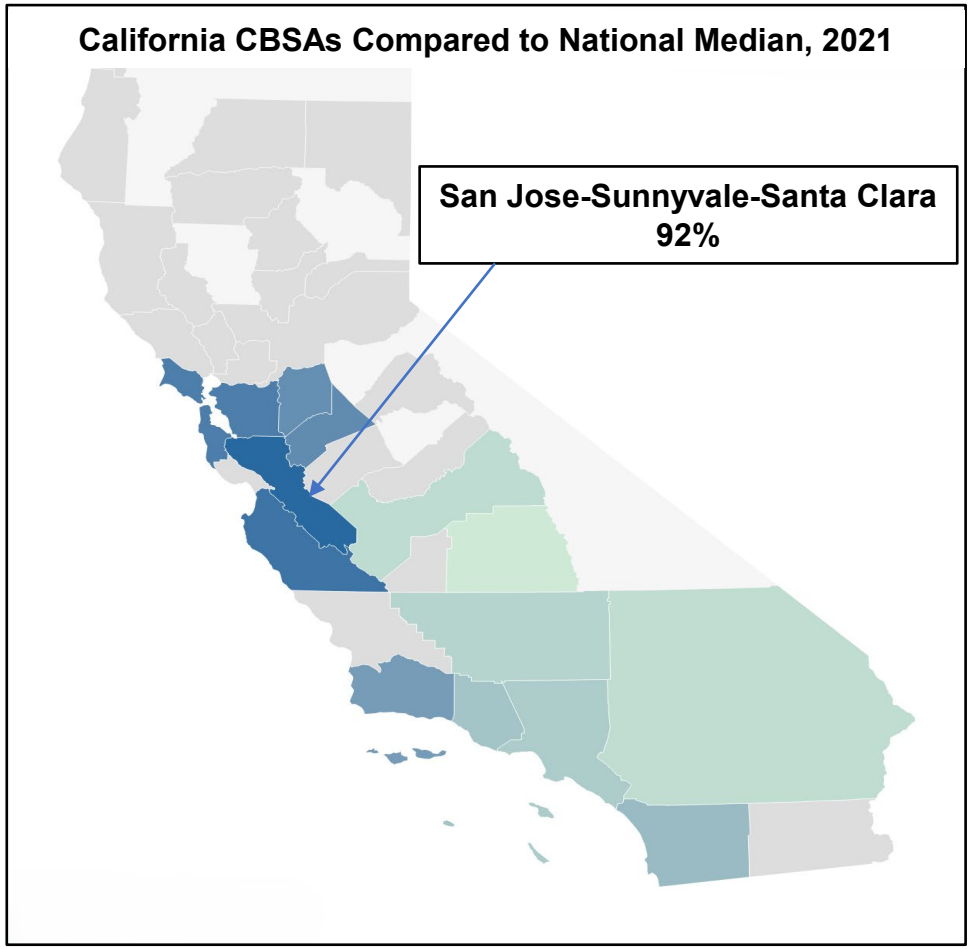
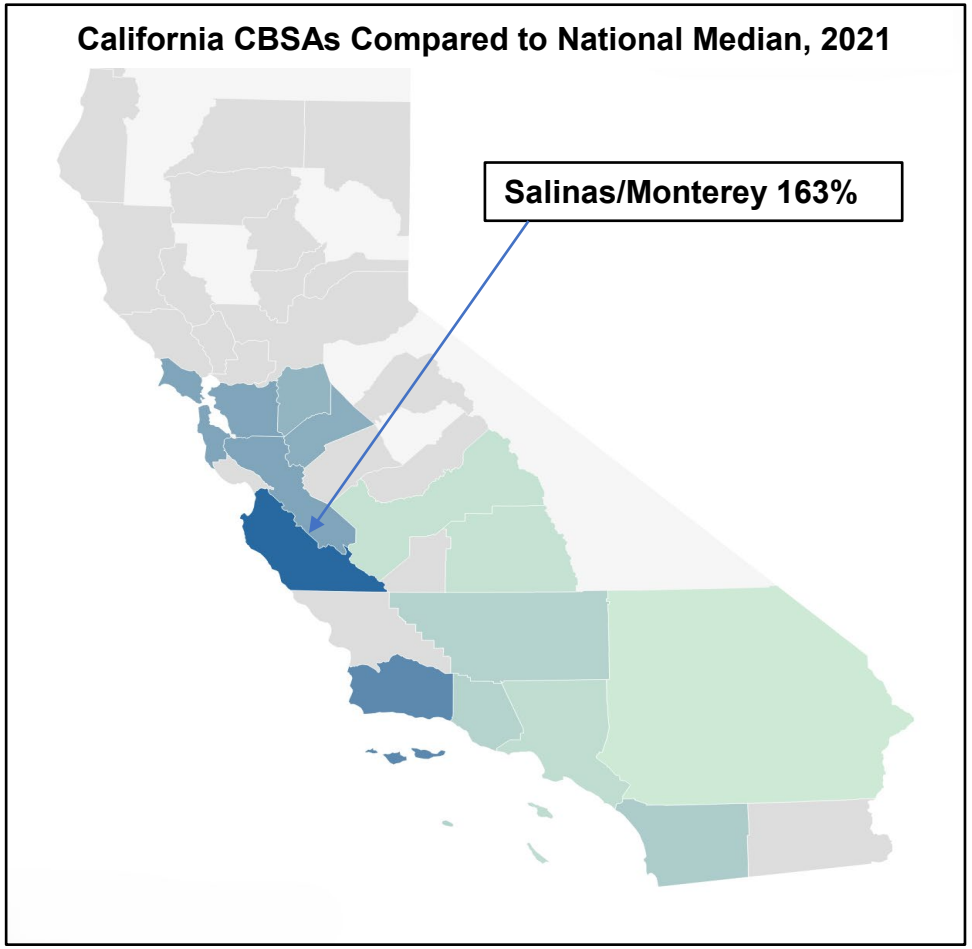
Overall Prices in Metropolitan Areas Above the National Median in 2021



Core-Based Statistical Area	Difference from National Median
San Jose-Sunnyvale-Santa Clara	92%
Salinas/Monterey	84%
San Francisco-Oakland-Hayward	77%
Modesto	67%
Stockton-Lodi	65%
Santa Maria-Santa Barbara	56%
San Diego-Carlsbad	36%
STATEWIDE AVERAGE	36%
Oxnard-Thousand Oaks-Ventura	30%
Los Angeles-Long Beach-Anaheim	25%
Bakersfield	20%
Fresno	15%
Riverside-San Bernardino-Ontario	14%
Visalia-Porterville	6%

Note: The gray areas did not meet the criteria for inclusion in the Healthy Marketplace Index (population, coverage and utilization too small or rural to report at a CBSA level). Source: Health Care Cost Institute, *Healthy Marketplace Index, 2017-2021.* https://healthcostinstitute.org/hcci-originals/healthy-marketplace-index/hmi?highlight=WyJoZWFsdGh5IiwibWFya2V0cGxhY2UiXQ==; *Understanding Health Care Spending*, 2021. https://healthcostinstitute.org/hcci-originals/hmi-interactive#HMI-Summary-Report-Current-Spending

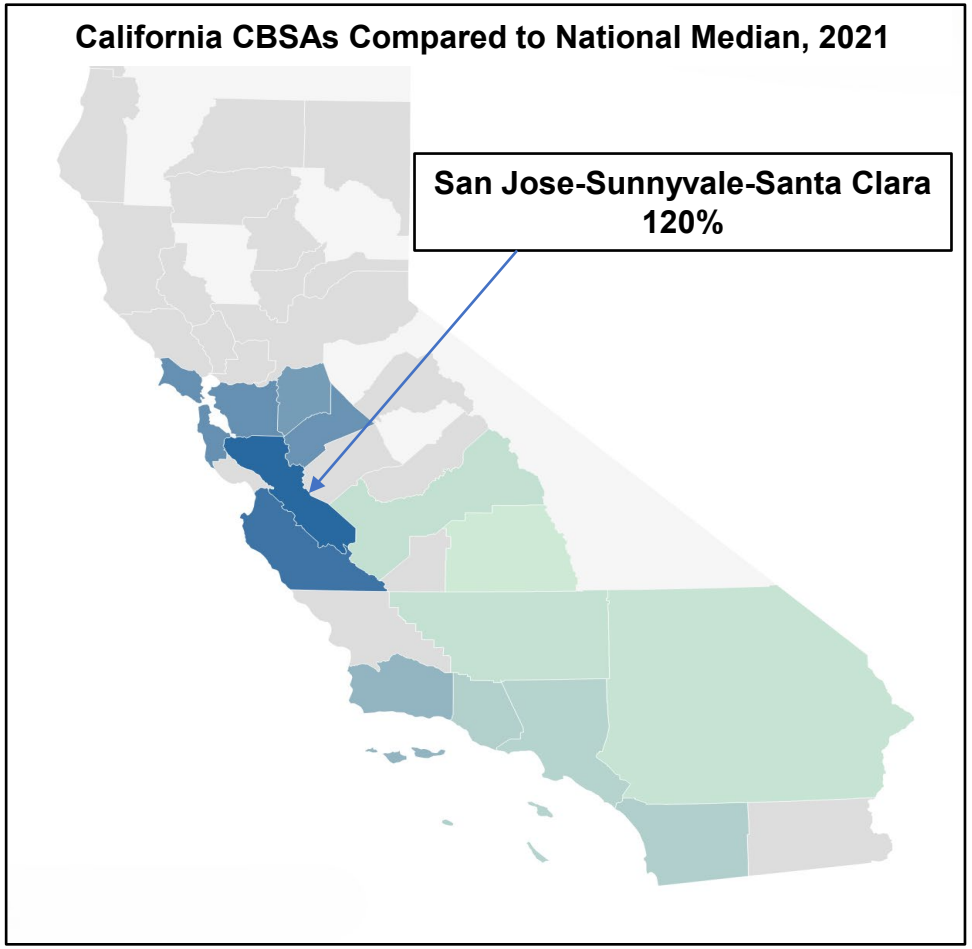
Inpatient Prices in Metropolitan Areas Above the National Median in 2021



Core-Based Statistical Area	Difference from National Median
Salinas/Monterey	163%
Santa Maria-Santa Barbara	127%
San Francisco-Oakland-Hayward	97%
San Jose-Sunnyvale-Santa Clara	97%
Modesto	87%
Stockton-Lodi	80%
San Diego-Carlsbad	56%
STATEWIDE AVERAGE	56%
Bakersfield	50%
Oxnard-Thousand Oaks-Ventura	49%
Los Angeles-Long Beach-Anaheim	39%
Fresno	34%
Visalia-Porterville	34%
Riverside-San Bernardino-Ontario	26%

Note: The gray areas did not meet the criteria for inclusion in the Healthy Marketplace Index (population, coverage and utilization too small or rural to report at a CBSA level). Source: Health Care Cost Institute, *Healthy Marketplace Index, 2017-2021.* https://healthcostinstitute.org/hcci-originals/healthy-marketplace-index/hmi?highlight=WyJoZWFsdGh5IiwibWFya2V0cGxhY2UiXQ==; *Understanding Health Care Spending*, 2021. https://healthcostinstitute.org/hcci-originals/hmi-interactive#HMI-Summary-Report-Current-Spending

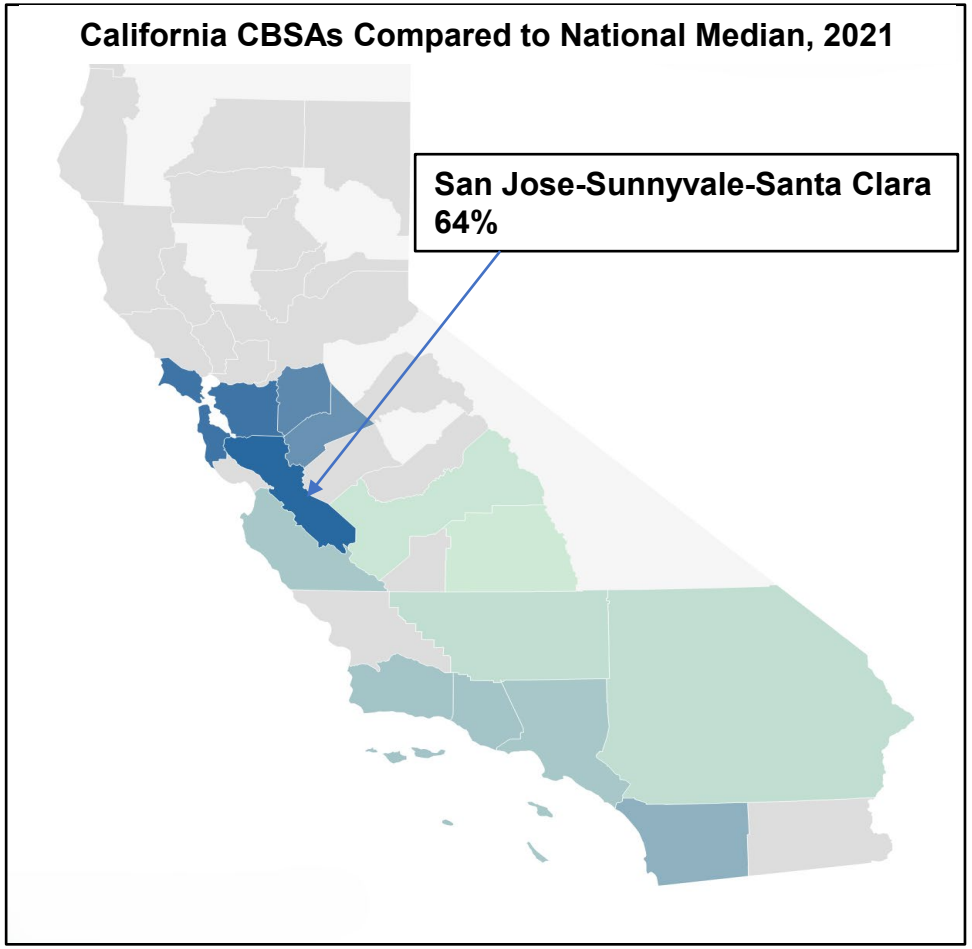
Outpatient Prices in Metropolitan Areas Above the National Median in 2021



Core-Based Statistical Area	Difference from National Median
San Jose-Sunnyvale-Santa Clara	120%
Salinas/Monterey	110%
San Francisco-Oakland-Hayward	86%
Modesto	83%
Stockton-Lodi	75%
Santa Maria-Santa Barbara	55%
San Diego-Carlsbad	34%
STATEWIDE AVERAGE	34%
Oxnard-Thousand Oaks-Ventura	33%
Los Angeles-Long Beach-Anaheim	30%
Fresno	21%
Bakersfield	20%
Riverside-San Bernardino-Ontario	18%
Visalia-Porterville	13%

Note: The gray areas did not meet the criteria for inclusion in the Healthy Marketplace Index (population, coverage and utilization too small or rural to report at a CBSA level). Source: Health Care Cost Institute, *Healthy Marketplace Index, 2017-2021.* https://healthcostinstitute.org/hcci-originals/healthy-marketplace-index/hmi?highlight=WyJoZWFsdGh5IiwibWFya2V0cGxhY2UiXQ==; *Understanding Health Care Spending*, 2021. https://healthcostinstitute.org/hcci-originals/hmi-interactive#HMI-Summary-Report-Current-Spending

Professional Prices in Most Metropolitan Areas Above the National Median in 2021

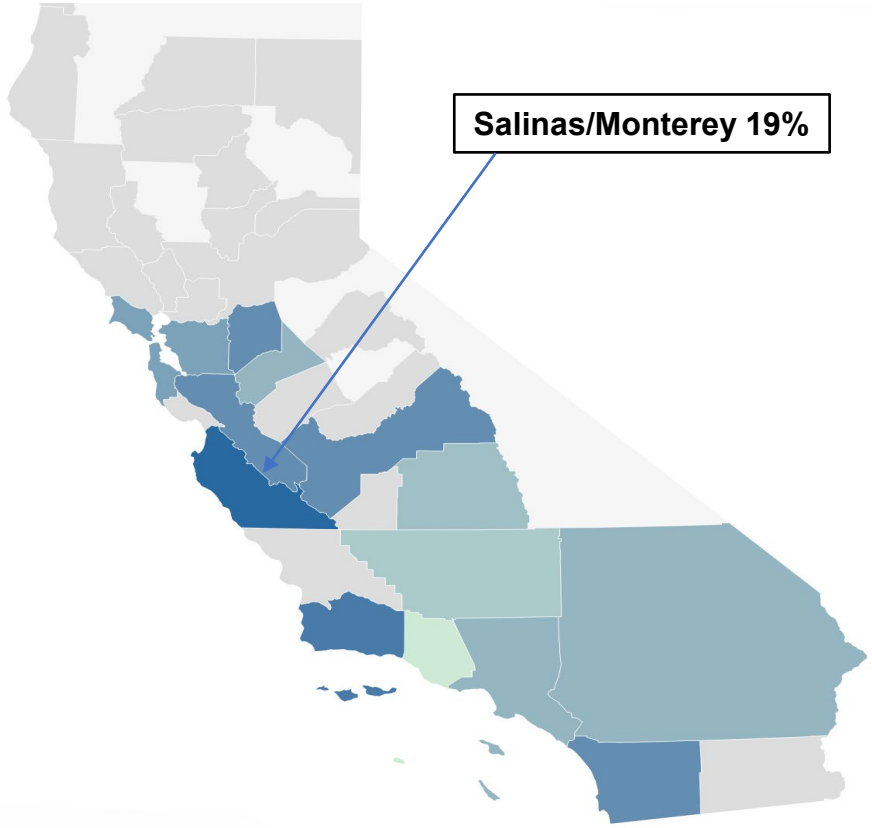


Core-Based Statistical Area	Difference from National Median
San Jose-Sunnyvale-Santa Clara	64%
San Francisco-Oakland-Hayward	57%
Stockton-Lodi	46%
Modesto	41%
San Diego-Carlsbad	25%
Oxnard-Thousand Oaks-Ventura	15%
Santa Maria-Santa Barbara	15%
STATEWIDE AVERAGE	15%
Los Angeles-Long Beach-Anaheim	13%
Salinas/Monterey	13%
Bakersfield	2%
Riverside-San Bernardino-Ontario	2%
Fresno	-2%
Visalia-Porterville	-4%

Note: The gray areas did not meet the criteria for inclusion in the Healthy Marketplace Index (population, coverage and utilization too small or rural to report at a CBSA level). Source: Health Care Cost Institute, *Healthy Marketplace Index, 2017-2021.* https://healthcostinstitute.org/hcci-originals/healthy-marketplace-index/hmi?highlight=WyJoZWFsdGh5IiwibWFya2V0cGxhY2UiXQ==; *Understanding Health Care Spending*, 2021. https://healthcostinstitute.org/hcci-originals/hmi-interactive#HMI-Summary-Report-Current-Spending

Most Metropolitan Areas Experienced Double-Digit Price Increases from 2017-2021

California CBSAs Compared to National Median, 2017-2021



Core-Based Statistical Area	Difference from National Median
Salinas/Monterey	19%
Santa Maria-Santa Barbara	17%
Fresno	15%
San Diego-Carlsbad	15%
San Jose-Sunnyvale-Santa Clara	15%
Stockton-Lodi	15%
San Francisco-Oakland-Hayward	13%
STATEWIDE AVERAGE	13%
Los Angeles-Long Beach-Anaheim	11%
Modesto	11%
Riverside-San Bernardino-Ontario	11%
Visalia-Porterville	10%
Bakersfield	9%
Oxnard-Thousand Oaks-Ventura	6%

Note: The gray areas did not meet the criteria for inclusion in the Healthy Marketplace Index (population, coverage and utilization too small or rural to report at a CBSA level). Source: Health Care Cost Institute, *Healthy Marketplace Index, 2017-2021.* https://healthcostinstitute.org/hcci-originals/healthy-marketplace-index/hmi?highlight=WyJoZWFsdGh5IiwibWFya2V0cGxhY2UiXQ==; *Understanding Health Care Spending*, 2021. https://healthcostinstitute.org/hcci-originals/hmi-interactive#HMI-Summary-Report-Spending-Over-Time

HCAi
Department of Health Care Access and Information

Public Purchaser Perspectives

Jessica Altman, Executive Director, Covered California
Don Moulds, Chief Health Director, California Public Employees' Retirement System

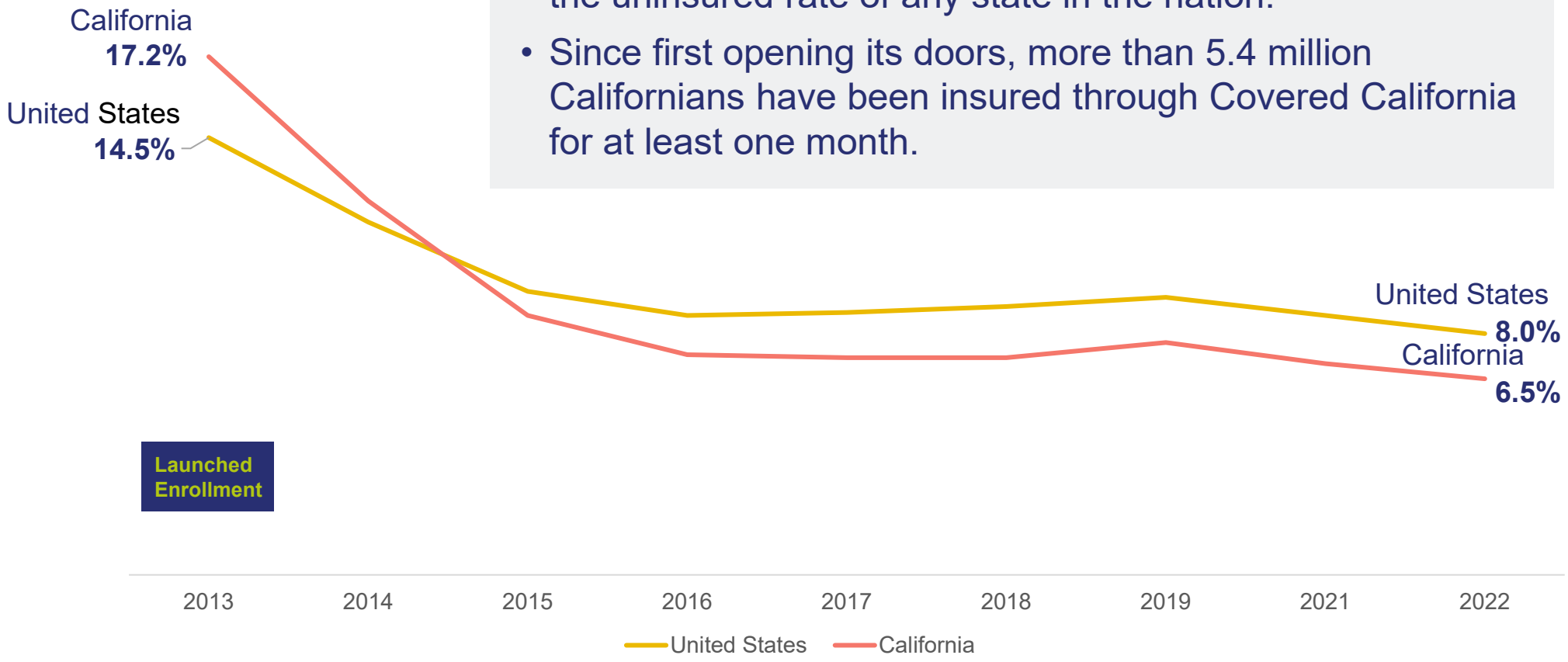
Jessica Altman, Executive Director, Covered California
Presentation to the Health Care Affordability Board
August 28, 2024

COVERED CALIFORNIA OVERVIEW

RECORD DECREASE IN CALIFORNIA'S UNINSURED RATE

Comparing the Rate of Uninsured in California and the United States

- California experienced the largest percentage point drop in the uninsured rate of any state in the nation.
- Since first opening its doors, more than 5.4 million Californians have been insured through Covered California for at least one month.



***Source: American Community Survey, 2022** -American Community Survey Accuracy of the Data (2022) (census.gov).
The rates for uninsured are shown for populations of all ages.

COVERED CALIFORNIA

The American Community Survey (ACS) is an annual demographics survey program conducted by the U.S. Census Bureau. U.S. Census data on California's uninsured rate in 2020 has been delayed due to the pandemic and is not reflected.

COVERED CALIFORNIA AT A GLANCE

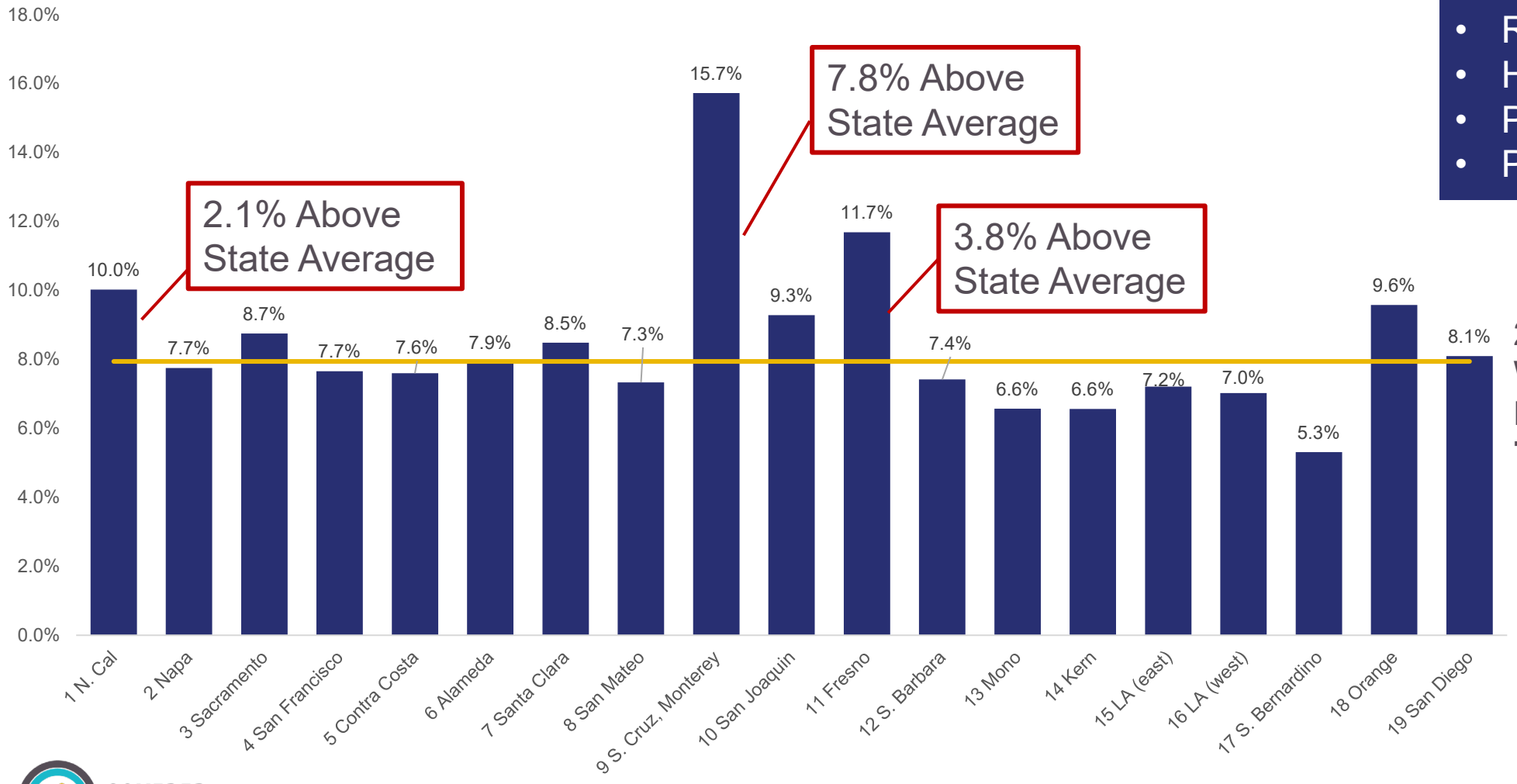
- Covered California is an Active Purchaser and negotiates with carriers on behalf of consumers to deliver the best value.
- Covered California provides quality health coverage from 12 health insurance carriers that meet all the state and federal requirements for health plans, plus additional contractual requirements set by Covered California.
- Health companies offer one or more of these products: PPO, HMO, and/or EPO; and a wide variety of doctors and hospitals.

12
Carriers

1.74 M
Enrollees

88%
Enrollees Subsidized

COVERED CALIFORNIA'S 2025 PRELIMINARY RATES

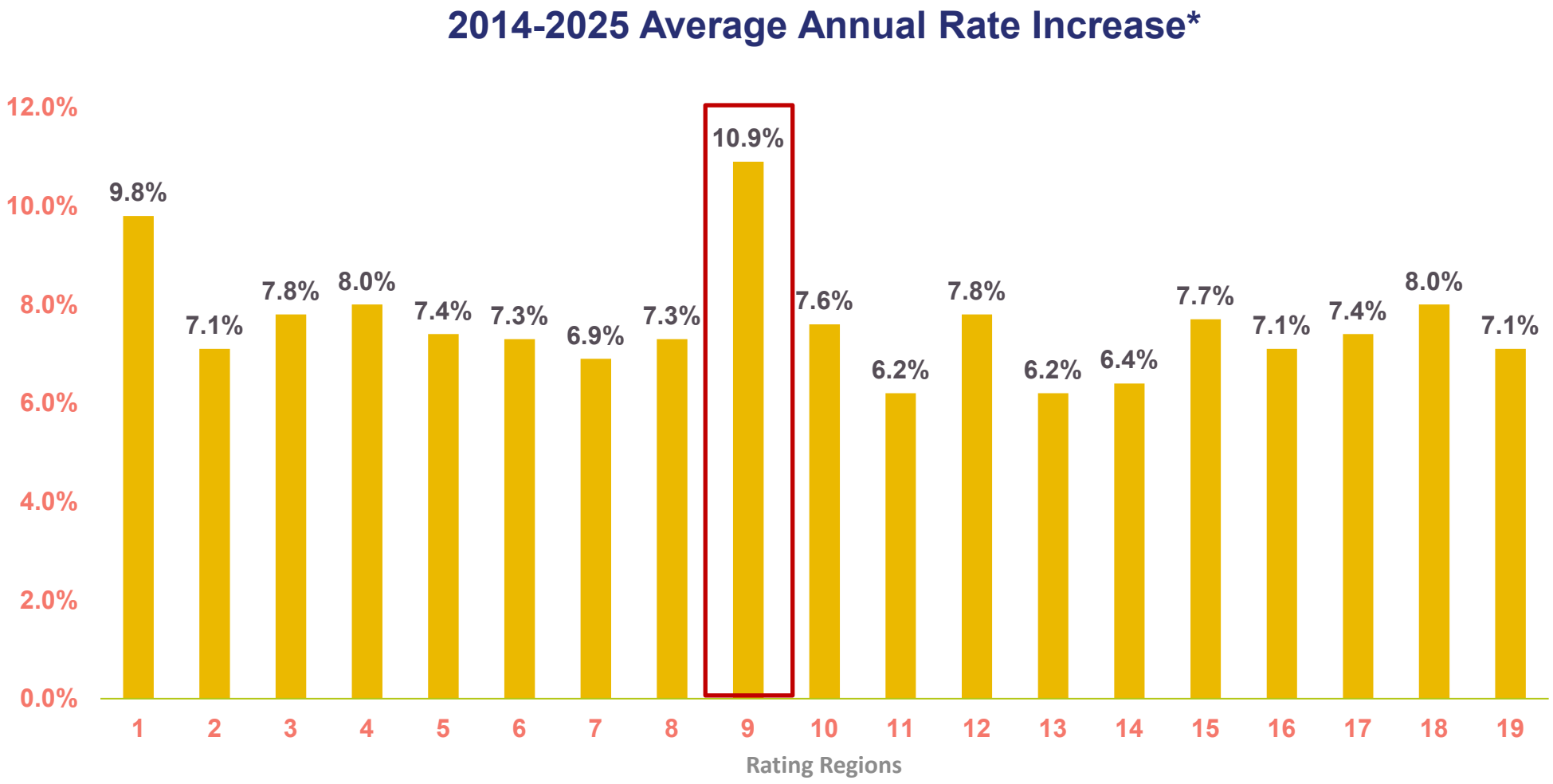


Factors impacting Rates

- Regional Geography
- Health Status
- Pharmaceutical Costs
- Provider Contracts

2025 Statewide Weighted Average Rate Change: **7.9%**

AVERAGE ANNUAL RATE INCREASE BY REGION: 2014 TO 2025



KEY: Rating Regions

1	N. Cal
2	Napa
3	Sacramento
4	San Francisco
5	Contra Costa
6	Alameda
7	Santa Clara
8	San Mateo
9	S. Cruz, Monterey
10	San Joaquin
11	Fresno
12	S. Barbara
13	Mono
14	Kern
15	LA (east)
16	LA (west)
17	S. Bernardino
18	Orange
19	San Diego

Throughout Covered California's history, Region 9 has averaged consistently higher rate increases than other regions throughout the state.

COVERED CALIFORNIA

*Rate Change is the average rate increase, compounded annually.

REGION 9 PROFILE
2025

REGION 9 SNAPSHOT

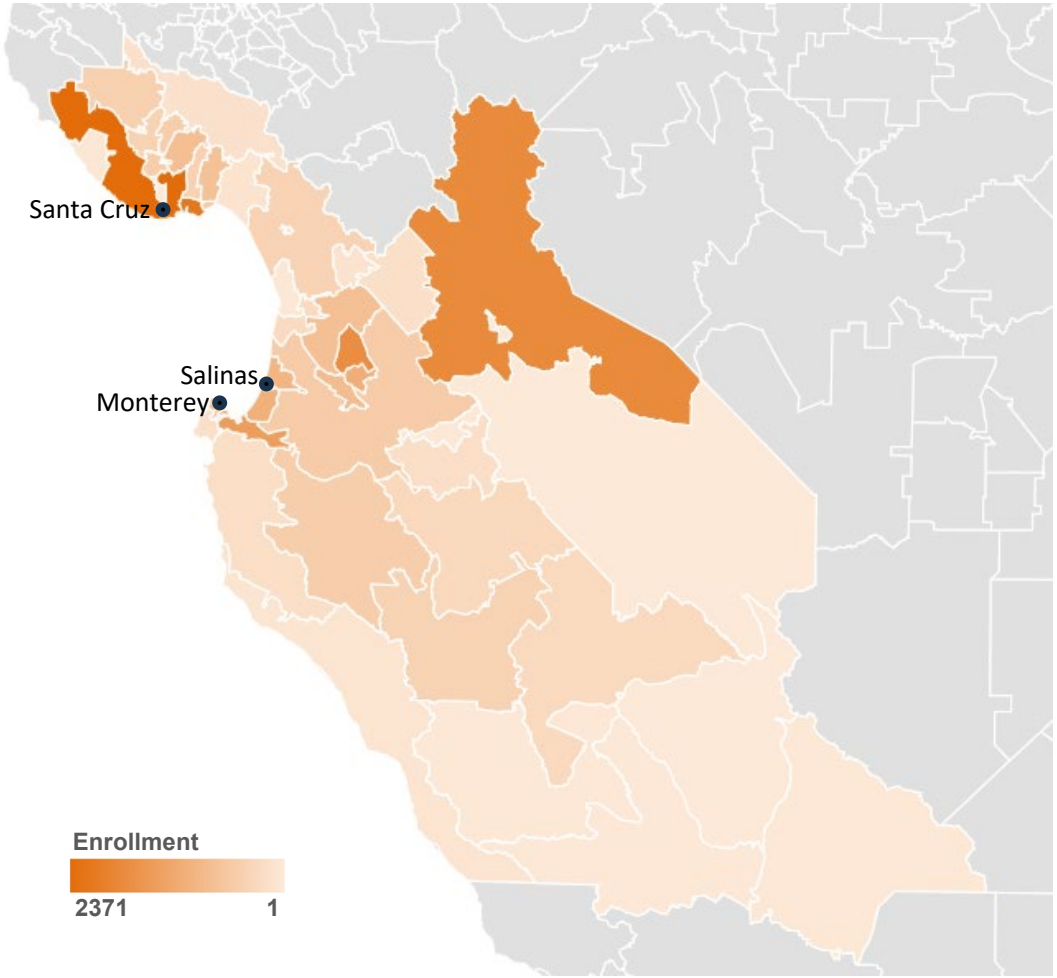
Region 9 is comprised of Monterey, Santa Cruz, San Benito. For Plan Year 2025, Anthem, Blue Shield of California, and Kaiser Permanente will serve approximately 27,000 enrollees in the region.

County	General Acute Care Hospitals	Number of Beds[1]
Monterey	Community Hospital of the Monterey Peninsula (CHOMP) George L. Mee Memorial Hospital Natividad Medical Center Salinas Valley Health Medical Center	286 73 172 263
San Benito	Hazel Hawkins	144
Santa Cruz	Dignity Health - Dominican Hospital Sutter Maternity and Surgery Center of Santa Cruz Watsonville Community Hospital	222 28 106

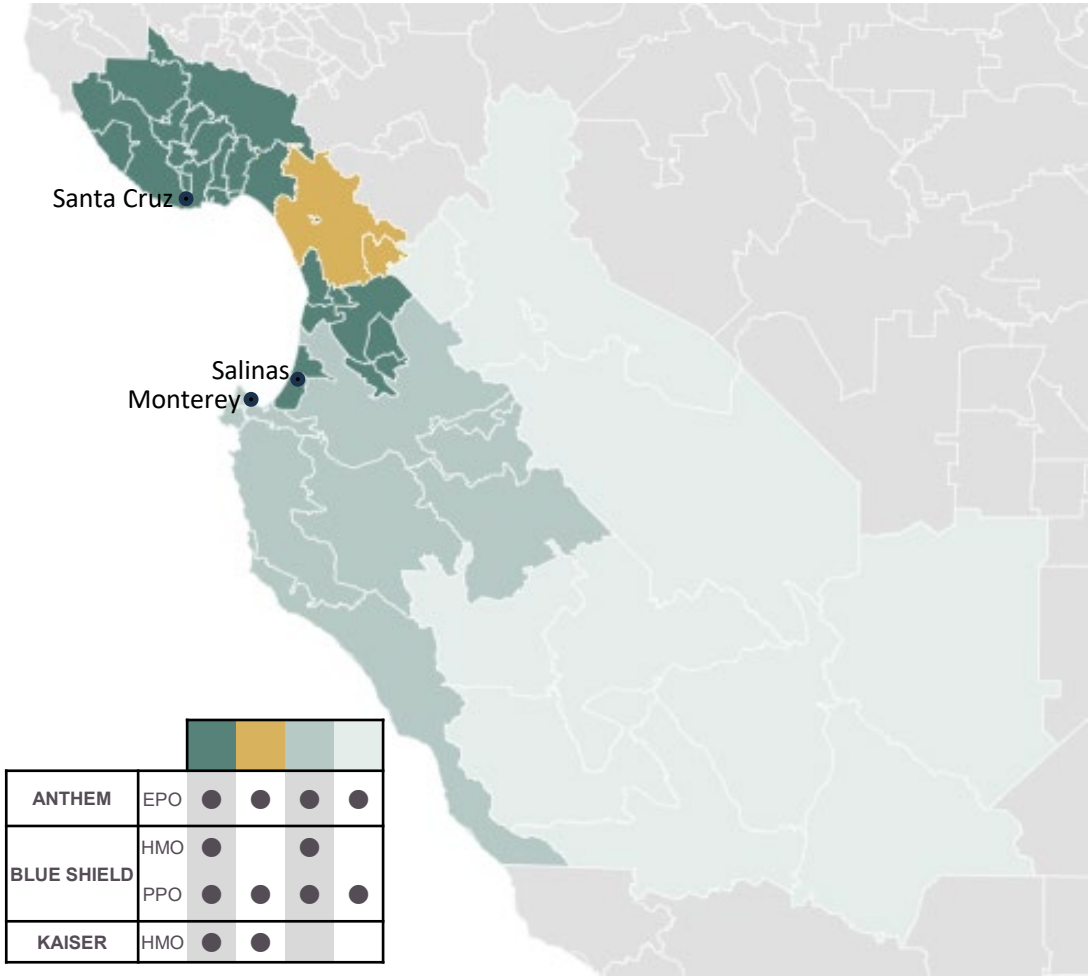
[1]Source: https://data.chhs.ca.gov/dataset/hospital-annual-financial-data-selected-data-pivot-tables

REGION 9: 2025 HEALTH INSURANCE CARRIERS AND ENROLLMENT BY ZIP CODE

Enrollment Distribution by Zip Code

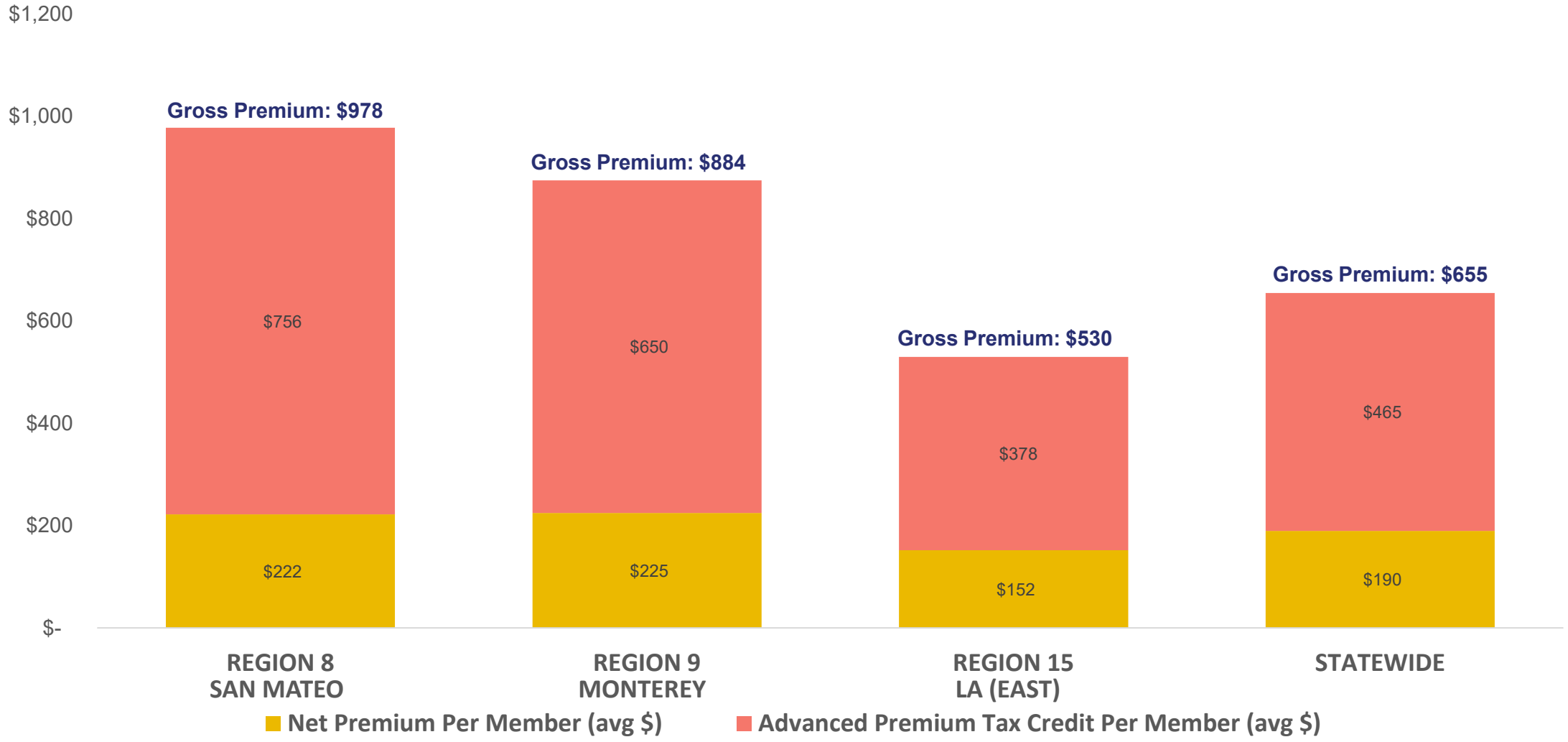


Plan & Carrier Availability by Zip Code



ANTHEM	EPO	●	●	●	●
BLUE SHIELD	HMO	●		●	
	PPO	●	●	●	●
KAISER	HMO	●	●		

REGION 9 PERSPECTIVE: 2024 PREMIUMS ARE SIGNIFICANTLY HIGHER THAN THE STATEWIDE AVERAGE, THOUGH NOT THE HIGHEST



REGION 9: HEALTHY RISK, YET HIGH PRICES

- Throughout Covered California's history, Region 9 risk scores have been substantially lower than the state overall.
- From 2018 on, the average risk score for Region 9 is 15 percent less than that of the state for the same carriers who operate in the region.
- Health status is not a primary driver of higher premiums in the region.

REGION 9: CARRIER EXPERIENCE

- **Contracting Challenges and High Costs:** Carriers such as Blue Shield of California, VHP, and Kaiser Permanente report encountering difficulties negotiating with hospitals like the Community Hospital of the Monterey Peninsula (CHOMP) and Salinas Valley Memorial, which prefer billed charge-based contracts. Kaiser has no contract with any hospital in Monterey County.

- **Network Adequacy:** Limited direct contracts with major hospitals and complex physician-hospital relationships, especially at CHOMP and Salinas Valley Memorial, challenge the deployment of new medical groups, clinics, and innovative payment models.

- **Market Exits:** VHP will exit Region 9 in 2025 due to high costs and provider access issues, while Blue Shield of California, despite considering withdrawal, will continue operating in Monterey through 2025.

KEY TAKEAWAYS

KEY TAKEAWAYS

- Throughout Covered California's history, Region 9 consistently experiences higher costs and premium growth compared to the rest of the state.
- Region 9's risk pool is generally healthier compared to the rest of the state. Health status is not a driver of premiums.
- Consumers in Region 9 benefit from carrier competition, but unique dynamics related to provider networks and cost create a less stable environment than other regions:
  - Health plans not in the region have difficulty entering with a competitive product.
- Covered California will continue to use its role in the marketplace to keep costs as low as possible for consumers, and is supportive of OHCA's efforts to hold plans, providers, and others in the health care space accountable to meeting cost targets.
- Dynamics like those in Region 9 are significant challenges for carriers, and will impact their ability to meet OHCA's targets.

THANK YOU!

CalPERS Regional Cost Variation

Don Moulds, PhD
Chief Health Director

CalPERS Health Overview

CalPERS Health Benefits Program

1.5 million
Members

1,200
Number of employers that contract for health benefits

$10.6 billion
Spent to purchase health benefits in 2022

Membership by Employer:

58%
State Members

28%
Public Agency Members

14%
School Members

Exceptional Health Care

Ensure our members receive **high-quality** care

Ensure our members have **access** to care when and where they need it

Ensure the care we provide is **affordable**

Ensure our members receive **equitable** care

Regional Cost Variation Analysis

Relative price for a vaginal delivery without complicating diagnoses by county, 2023

County	Allowed per Admit	Relative to Average
Yuba	$26,214	1.90
Monterey	$26,128	1.89
Santa Barbara	$20,186	1.46
Contra Costa	$20,014	1.45
Santa Cruz	$19,212	1.39
Shasta	$16,704	1.21
Santa Clara	$16,319	1.18
Statewide	**$13,795**	**1.00**
Sacramento	$13,508	0.98
Los Angeles	$13,056	0.95
San Diego	$10,025	0.73

Vaginal deliveries without complicating diagnoses (DRG 807)

Relative price for MRI by county, 2023

County	Average Allowed per Service	Relative to Average
Santa Clara	$875	1.56
Contra Costa	$835	1.49
Sacramento	$650	1.16
Santa Barbara	$574	1.02
Statewide	**$562**	**1.00**
Shasta	$556	0.99
Los Angeles	$554	0.98
Monterey	$456	0.81
San Diego	$455	0.81
San Bernardino	$409	0.73

MRI brain stem with and without contrast (CPT 70553 - all modifiers)

Relative price for electrocardiograms by county, 2023

County	Average Allowed per Service	Relative to Average
Sutter	$55	1.99
Santa Clara	$45	1.65
Contra Costa	$39	1.41
Monterey	$31	1.15
Santa Barbara	$29	1.07
Los Angeles	$28	1.00
Statewide	**$27**	**1.00**
Sacramento	$25	0.92
Shasta	$23	0.84
San Diego	$22	0.79

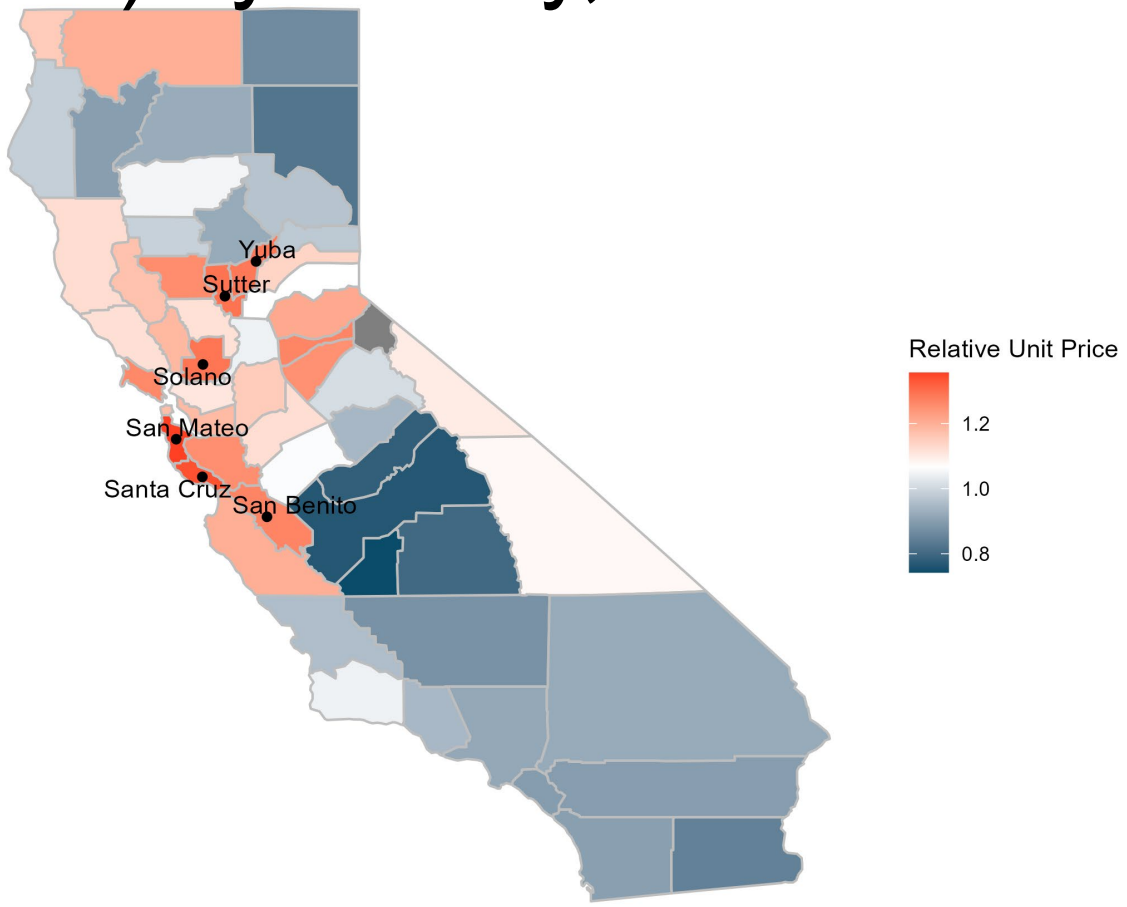
Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report (CPT 93000)

Relative price for emergency room facility charges by county, 2023

County	Average Allowed per Service	Relative to Average
Santa Clara	$1,947	1.69
Contra Costa	$1,773	1.54
Shasta	$1,680	1.46
Sacramento	$1,325	1.15
Monterey	$1,182	1.02
Statewide	**$1,154**	**1.00**
Sutter	$1,088	0.94
San Diego	$1,083	0.94
Los Angeles	$848	0.74
Santa Barbara	$789	0.68

Emergency room facility charges for evaluation and management of Level 3 visits – moderate severity (CPT 99283)

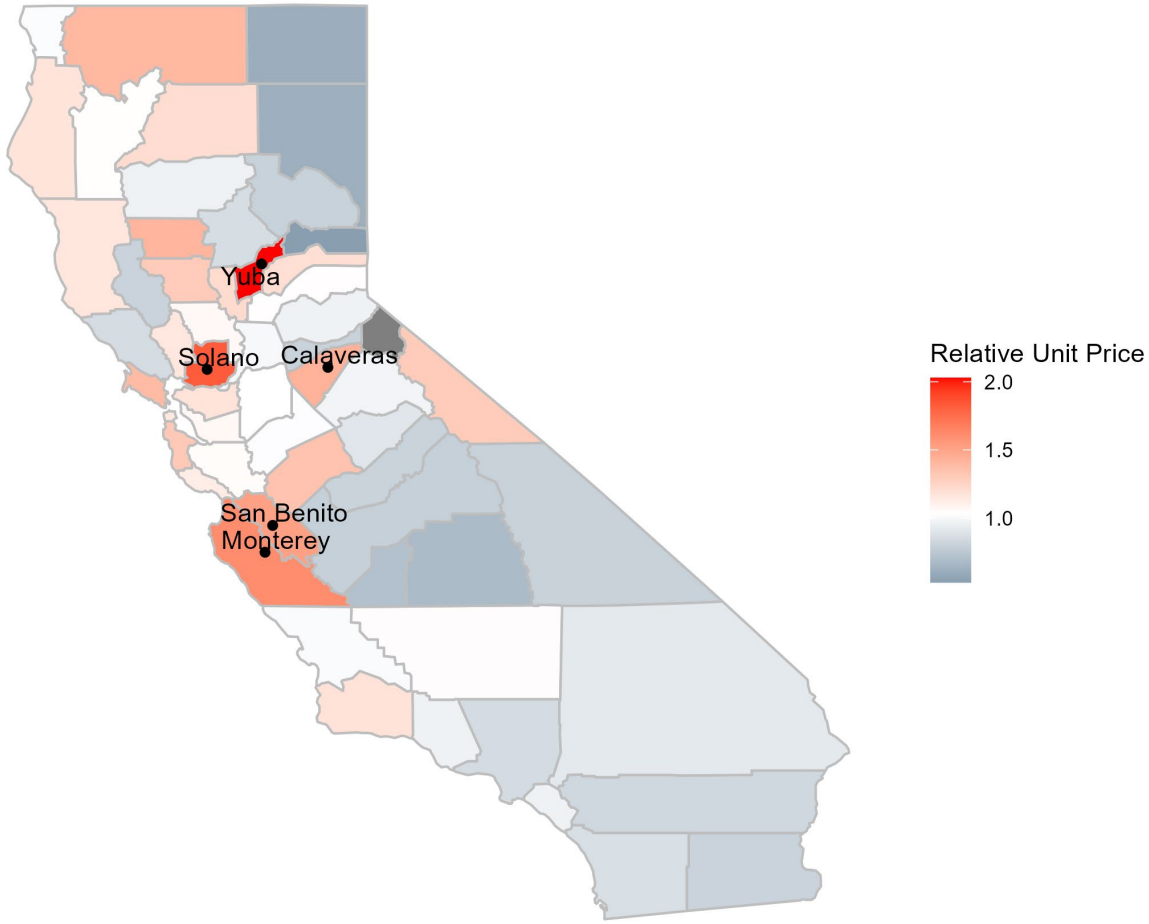
Overall relative total allowed per Global Relative Value Units (GRVU) by county, 2023



Composite overall relative total allowed per GRVU by county, 2023

County	Relative to Average
San Mateo	1.36
Sutter	1.29
Santa Clara	1.25
Monterey	1.20
Sacramento	1.04
Statewide	**1.00**
Los Angeles	0.92
Shasta	0.92
San Diego	0.90
Fresno	0.76

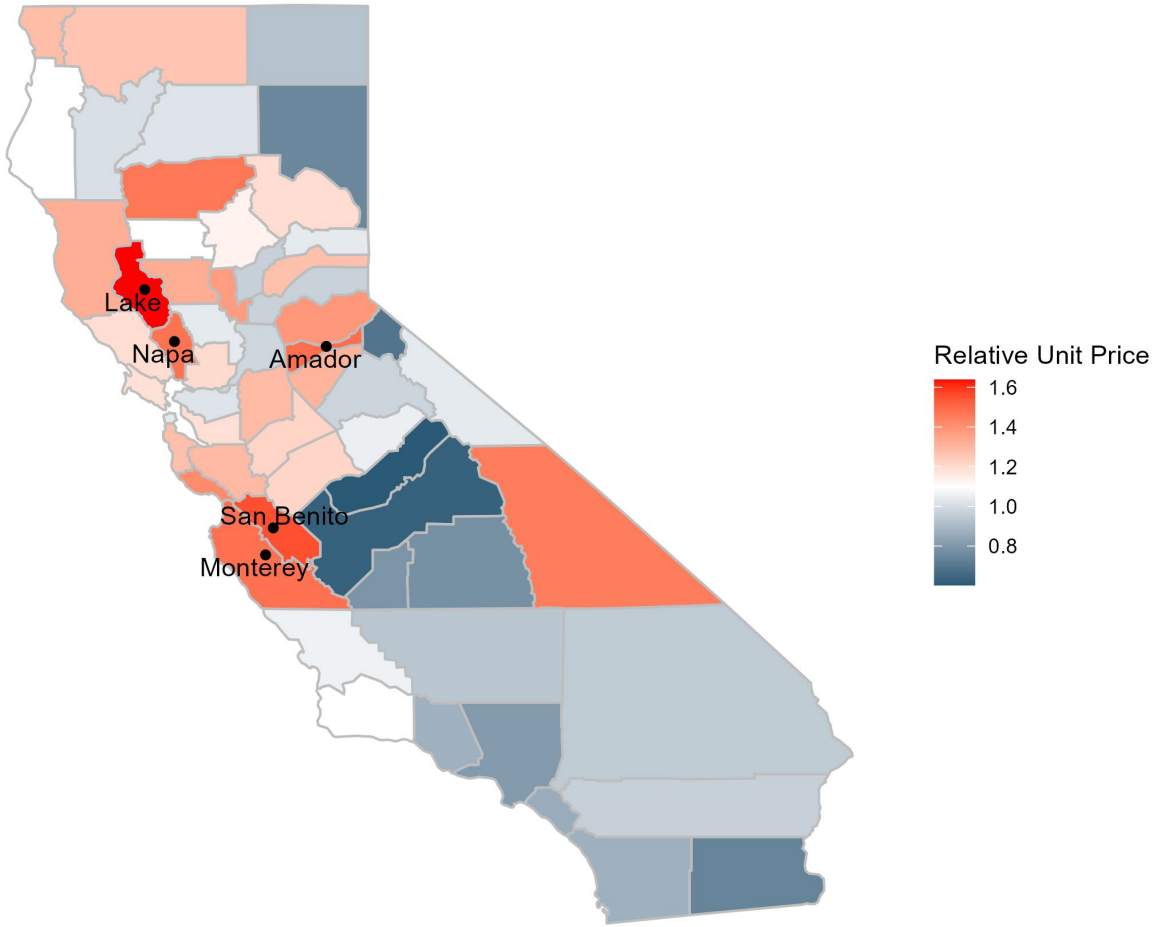
Hospital Inpatient services relative total allowed per GRVU by county, 2023



Hospital Inpatient relative total allowed per GRVU by county, 2023

County	Relative to Average
Yuba	2.03
Monterey	1.61
Shasta	1.21
Contra Costa	1.18
Santa Clara	1.05
Sacramento	1.00
Statewide	**1.00**
San Diego	0.87
Los Angeles	0.85
Fresno	0.79

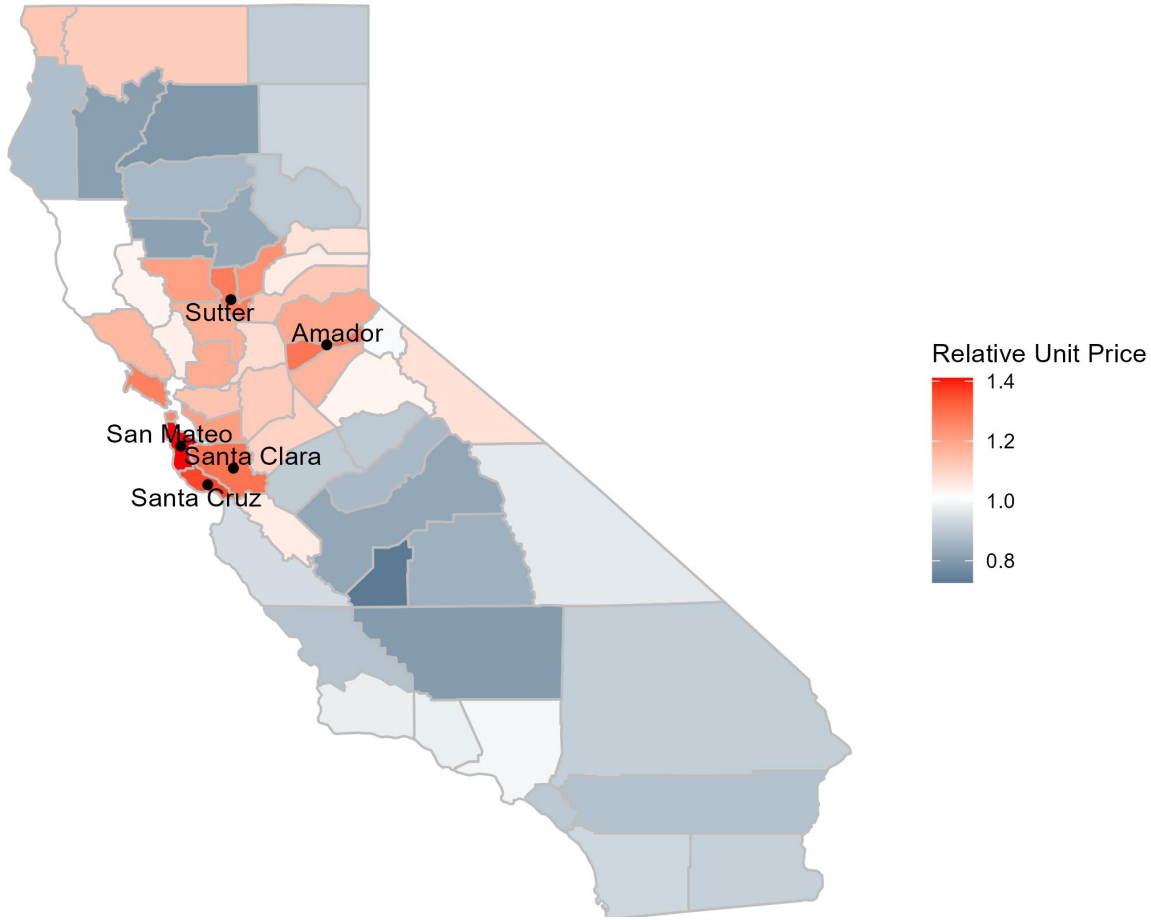
Hospital Outpatient services relative total allowed per GRVU by county, 2023



Hospital Outpatient relative total allowed per GRVU by county, 2023

County	Relative to Average
Monterey	1.48
Sutter	1.37
Santa Clara	1.29
Contra Costa	1.02
Shasta	1.02
Statewide	**1.00**
Sacramento	0.98
San Diego	0.88
Los Angeles	0.81
Fresno	0.63

Professional services relative total allowed per GRVU by county, 2023



Professional relative total allowed per GRVU by county, 2023

County	Relative to Average
Santa Clara	1.29
Sutter	1.27
Contra Costa	1.21
Sacramento	1.09
Statewide	**1.00**
Los Angeles	0.99
Monterey	0.94
San Diego	0.93
Fresno	0.83
Shasta	0.79

Takeaways

- Prices vary significantly across counties in California by Overall, Professional, Hospital Outpatient and Hospital Inpatient services
- Composite overall prices vary across the state by 82%
- Generally, prices are lower in Southern California and the Central Valley across all service categories
- CalPERS Northern California premiums are about $185 higher than in Southern California
- Higher prices are associated with lack of competition
- Prices are not associated with quality


Questions?

HCAi
Department of Health Care Access and Information

Public Comment

HCAi
Department of Health Care Access and Information

Case Study: Hospitals in Monterey County and State Options to Address High Costs

Vishaal Pegany, Deputy Director
CJ Howard, Assistant Deputy Director
Christopher Whaley, Ph.D., Brown University School of Public Health

Overview of Data Sources

1) HCAI - Hospital Annual Financial Data

- **Overview:** On an annual basis (individual hospital fiscal year), individual hospitals and hospital systems report detailed facility-level data to HCAI on services capacity, inpatient/outpatient utilization, patients, revenues and expenses by type and payer, balance sheet and income statement.
- **Length of Study:** 2012 - 2022
- **Link:** https://data.chhs.ca.gov/dataset/hospital-annual-financial-data-selected-data-pivot-tables

2) HCAI Healthcare Utilization - Patient Level Administrative Data

- **Overview:** Aggregates patient characteristics at the statewide, county, and facility-level to provide a calendar year overview of patients in general acute care hospital setting in California.
- **Length of Study:** 2017 - 2022
- **Link:** https://hcai.ca.gov/visualizations/patient-characteristics-by-county-and-facility/

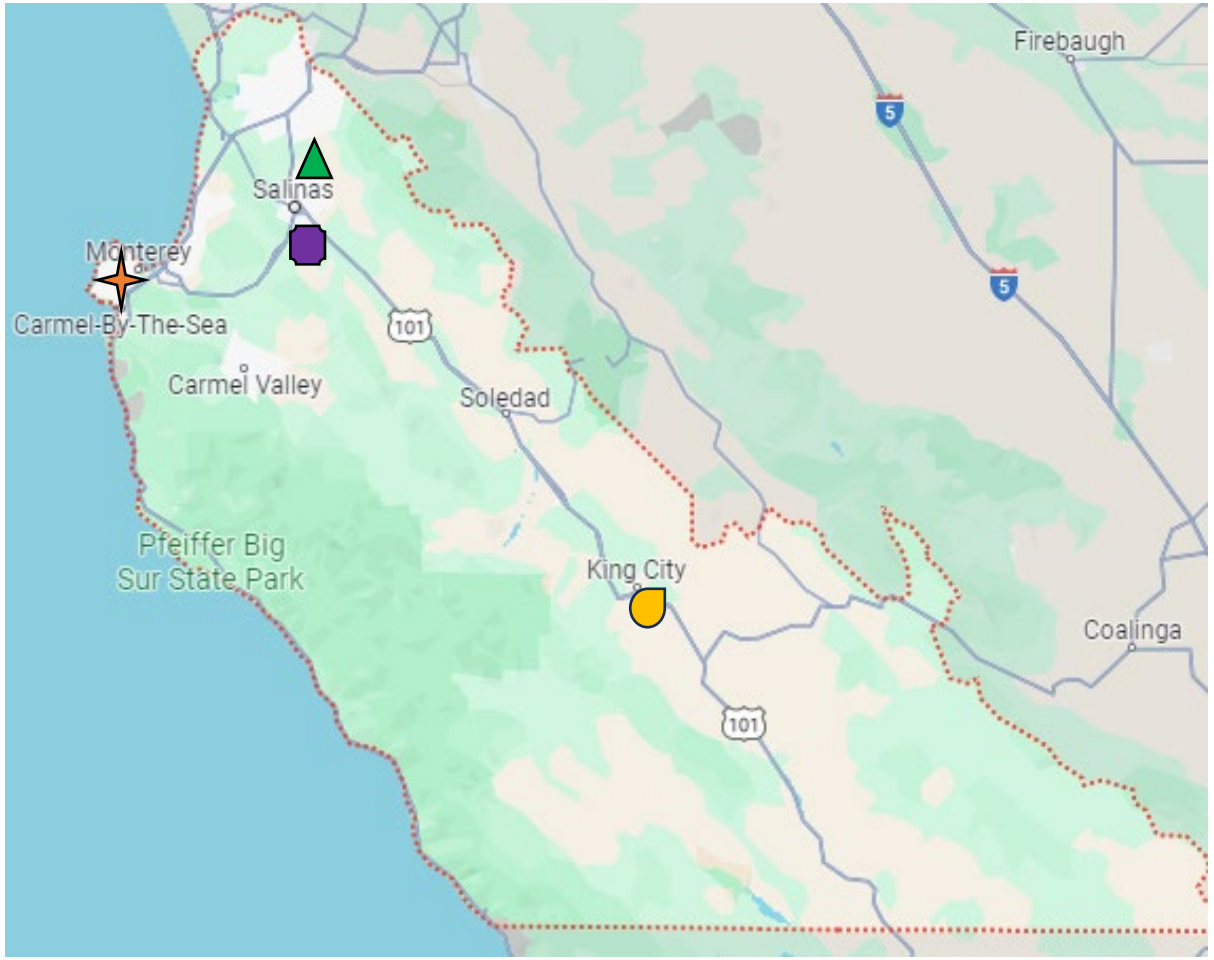
Hospitals in Monterey County

Community Hospital of the Monterey Peninsula*
- Nonprofit Hospital in Monterey, CA
- 286 Bed Count
- General and Acute Care provided
- IP Discharges (14,281), OP Visits (496,427) in 2022

Salinas Valley Memorial Health
- District Hospital in Salinas, CA
- 263 Bed Count
- General and Acute Care provided
- IP Discharges (10,930), OP Visits (101,485) in 2022

Natividad Medical Center
- Public Hospital in Salinas, CA
- 172 Bed Count
- Specialty Care and a Level II Trauma Center
- IP Discharges (8,927), OP Visits (173,871) in 2022

Mee Memorial Healthcare System**
- Nonprofit Hospital in King City, CA
- 73 Bed Count
- General and Acute Care provided
- IP Discharges (415), OP Visits (106,727) in 2022



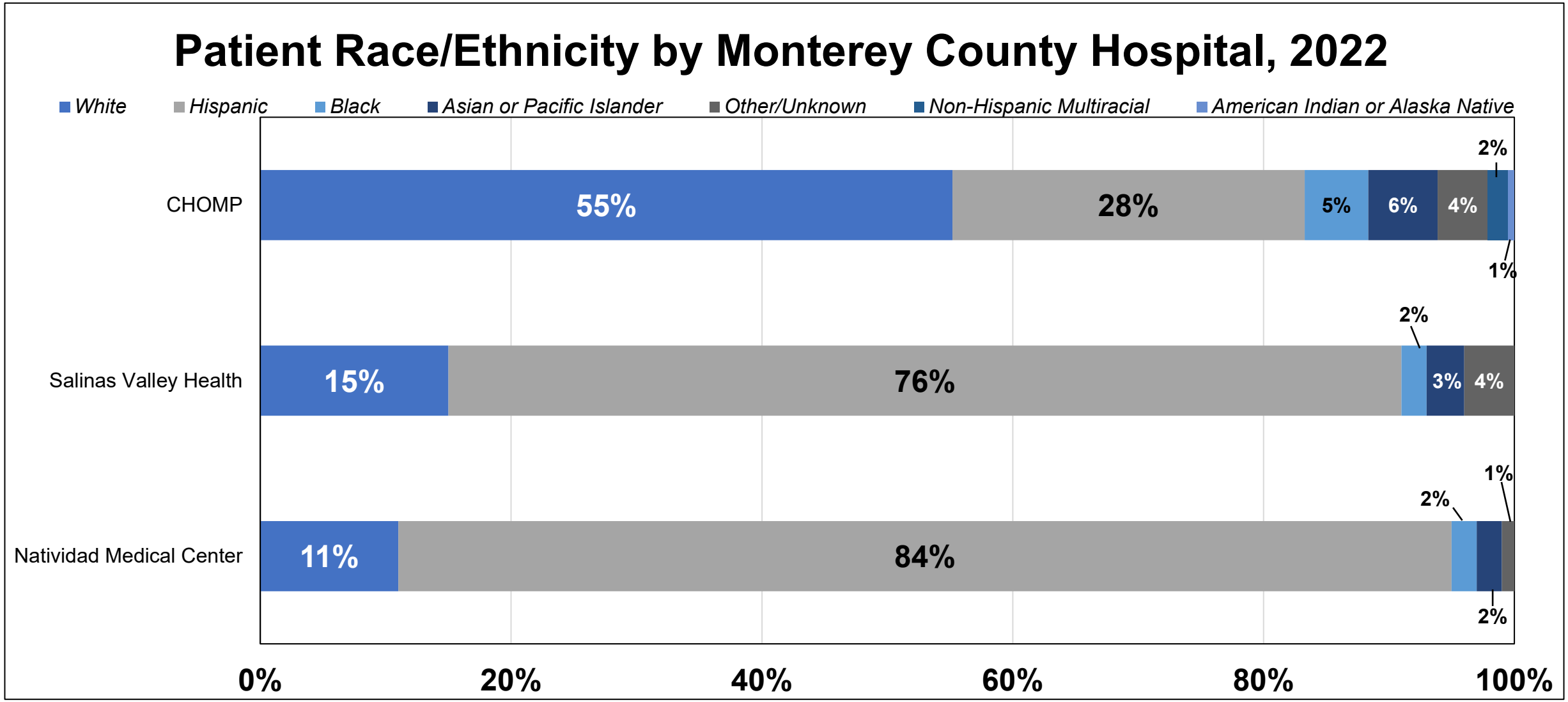
*Community Hospital is the hospital of Montage Health, a locally based and owned nonprofit network of medical services, doctors, and health facilities.
**Located 45 minutes driving distance from Salinas and 75 minutes from Monterey. Excluded from analysis.
Source of Patient Encounter and Bed Count data: HCAI - Hospital Annual Financial Data, 2022.

2022 Patient Profiles for CHOMP / SVH / Natividad

Comparison of Hospital Profiles

- CHOMP's patient population differs from the patient population in the Salinas-area hospitals (Natividad and Salinas Valley Health).
  - **Patient Race/Ethnicity**: CHOMP has a predominantly White patient population while Natividad and Salinas Valley Health have a predominantly Hispanic patient population.
  - **Patient Age Group**: CHOMP's patients skew older while the patients of Natividad and Salinas Valley Health skew younger.
  - **Patient Setting Type**: Natividad and Salinas Valley Health oversee a larger share of Emergency Department visits.
  - **Patient Payer**: Medicare is the dominant payer for CHOMP while Medi-Cal is for Natividad and Salinas Valley Health.

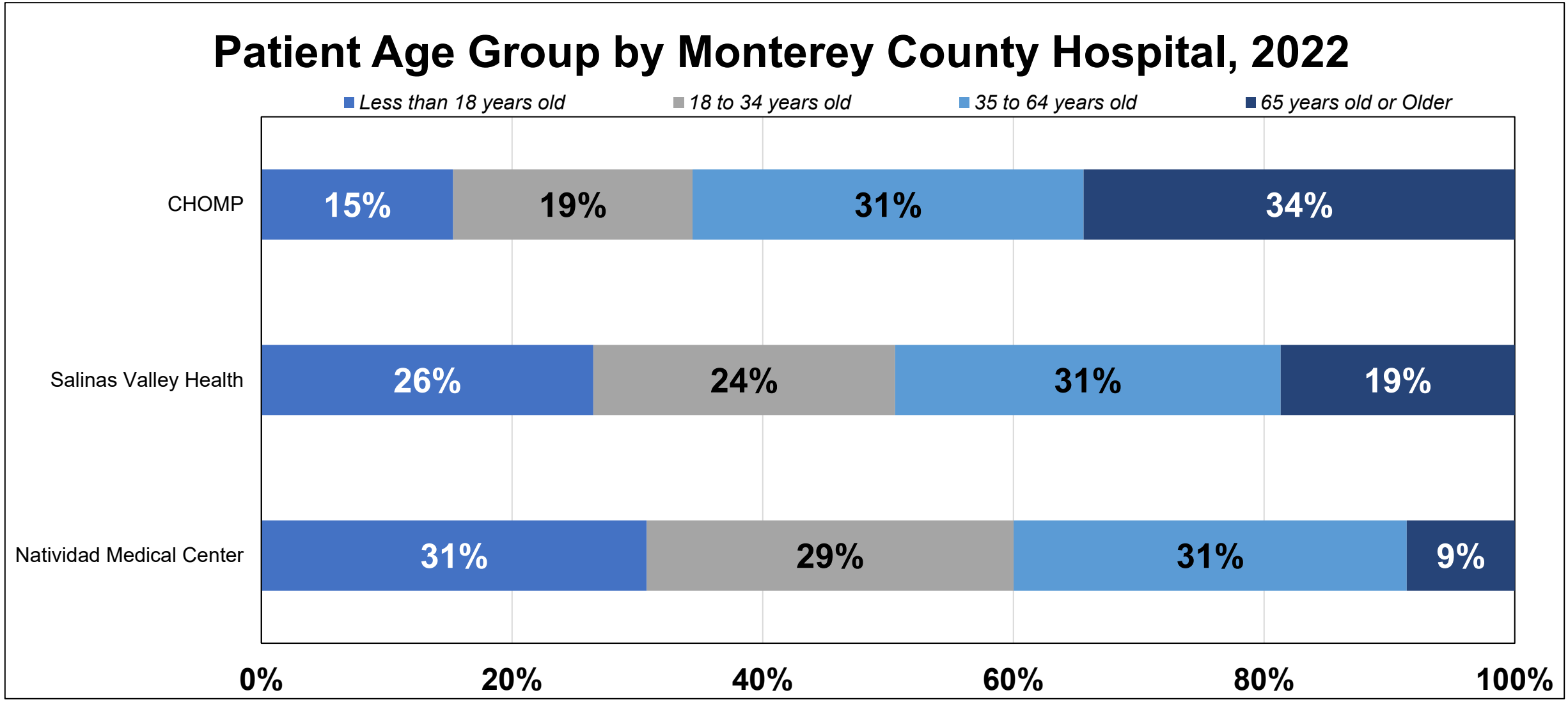
Comparing Hospital Patient Demographics



Source: HCAI Healthcare Utilization - Patient Level Administrative Data

HCAI Department of Health Care Access and Information

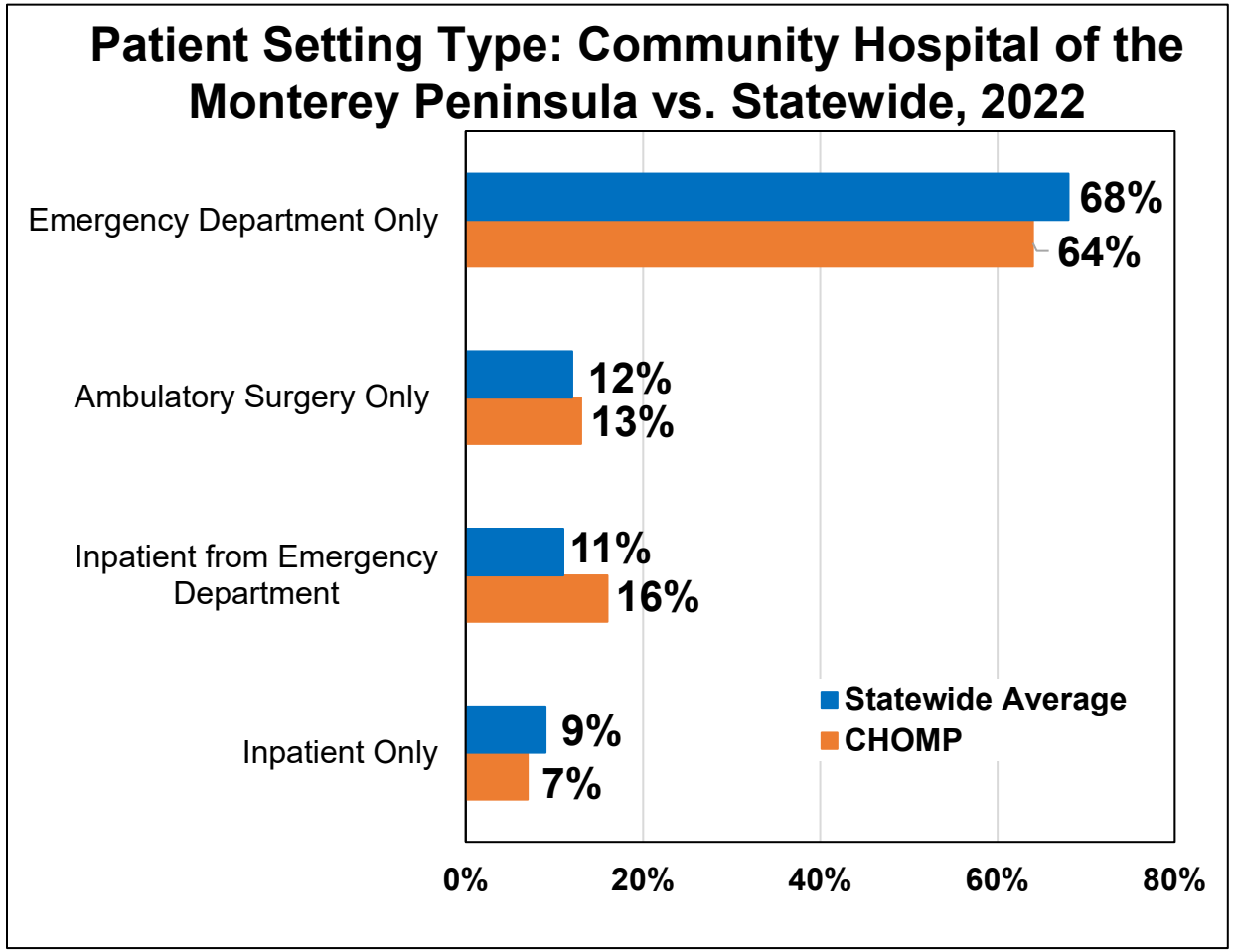
Comparing Hospital Patient Demographics

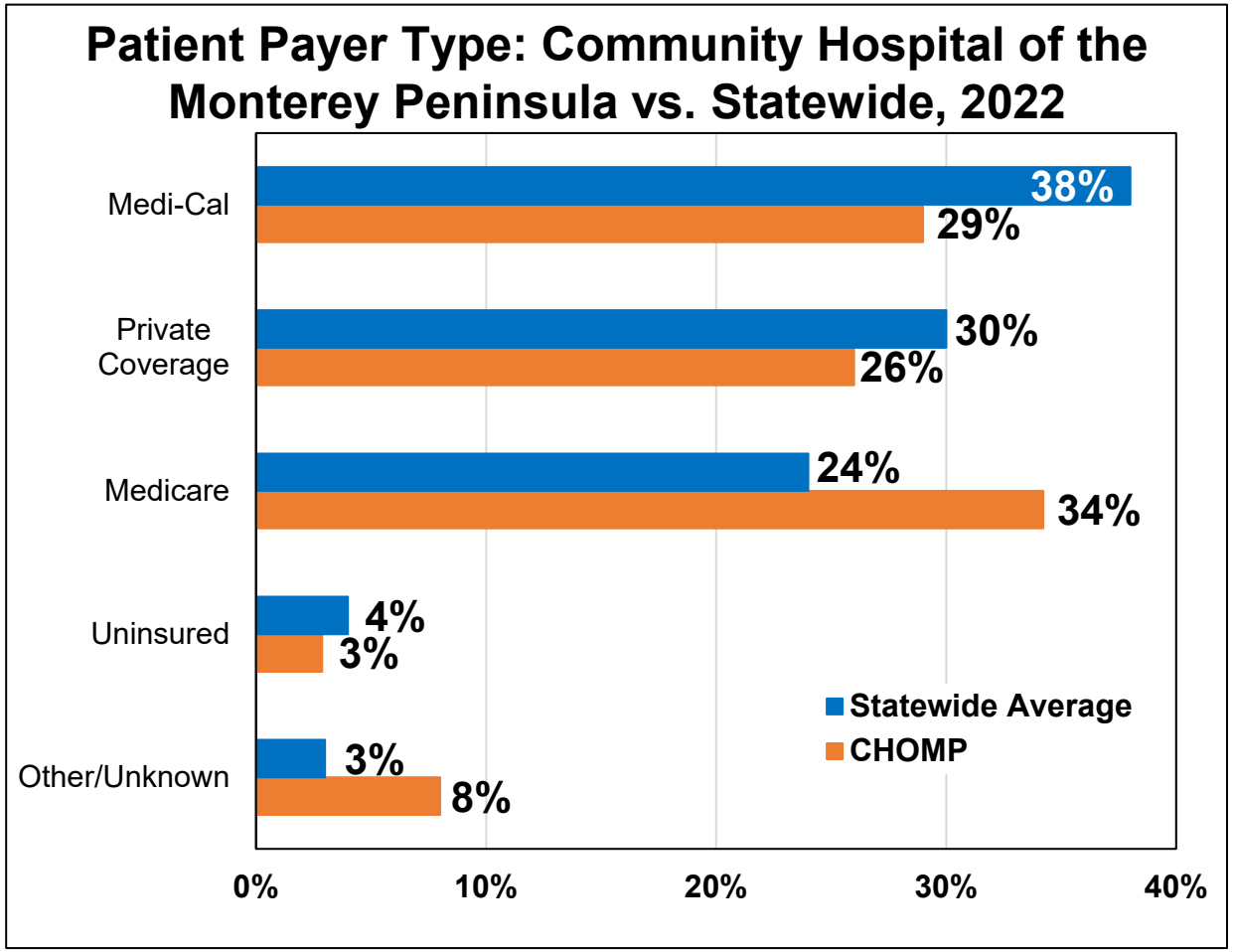


Source: HCAI Healthcare Utilization - Patient Level Administrative Data

HCAI Department of Health Care Access and Information

CHOMP vs. Statewide Average: Patient Setting Type and Payer Mix

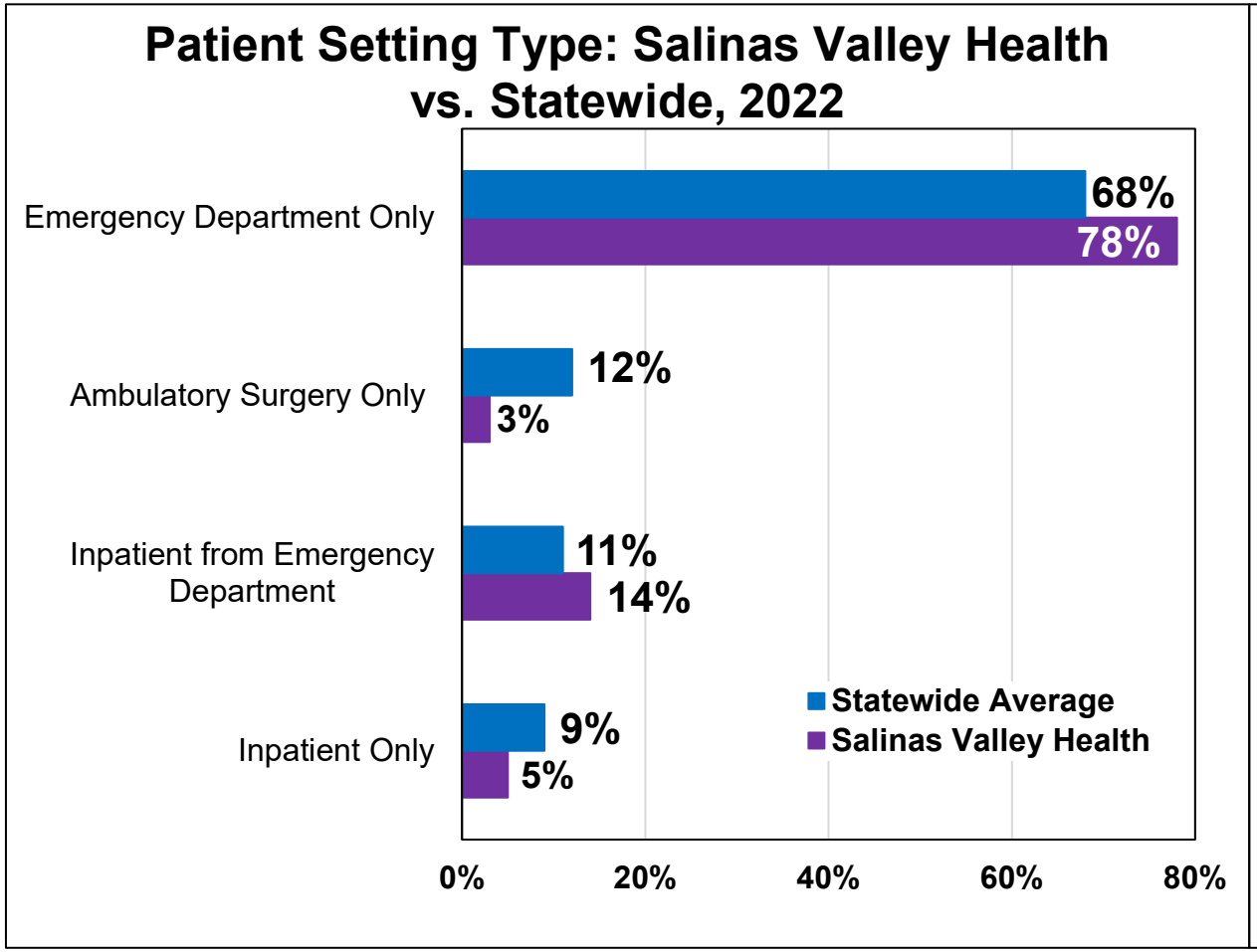


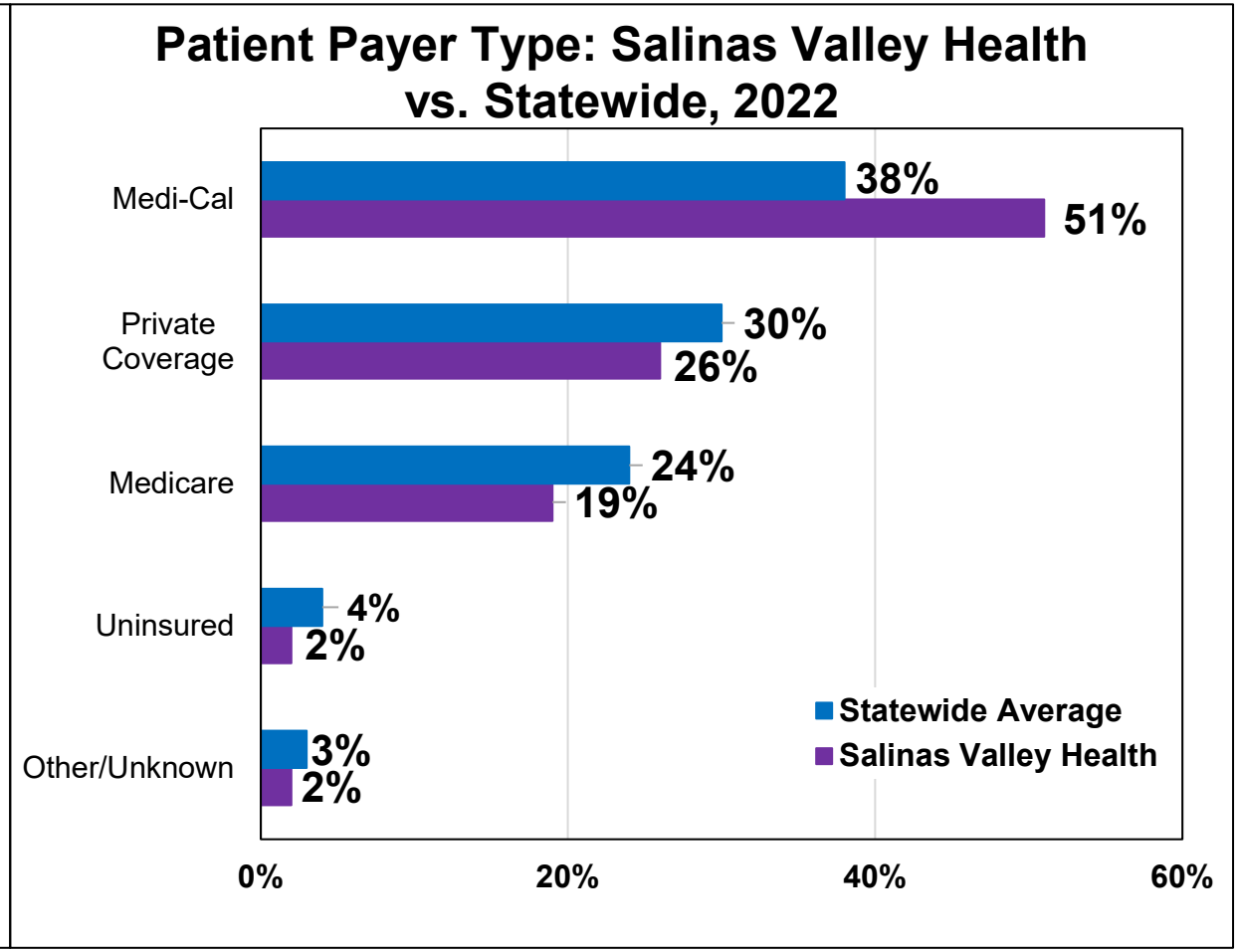


Source: HCAI Healthcare Utilization - Patient Level Administrative Data.

HCAI Department of Health Care Access and Information

Salinas Valley Health vs. Statewide Average: Patient Setting Type and Payer Mix

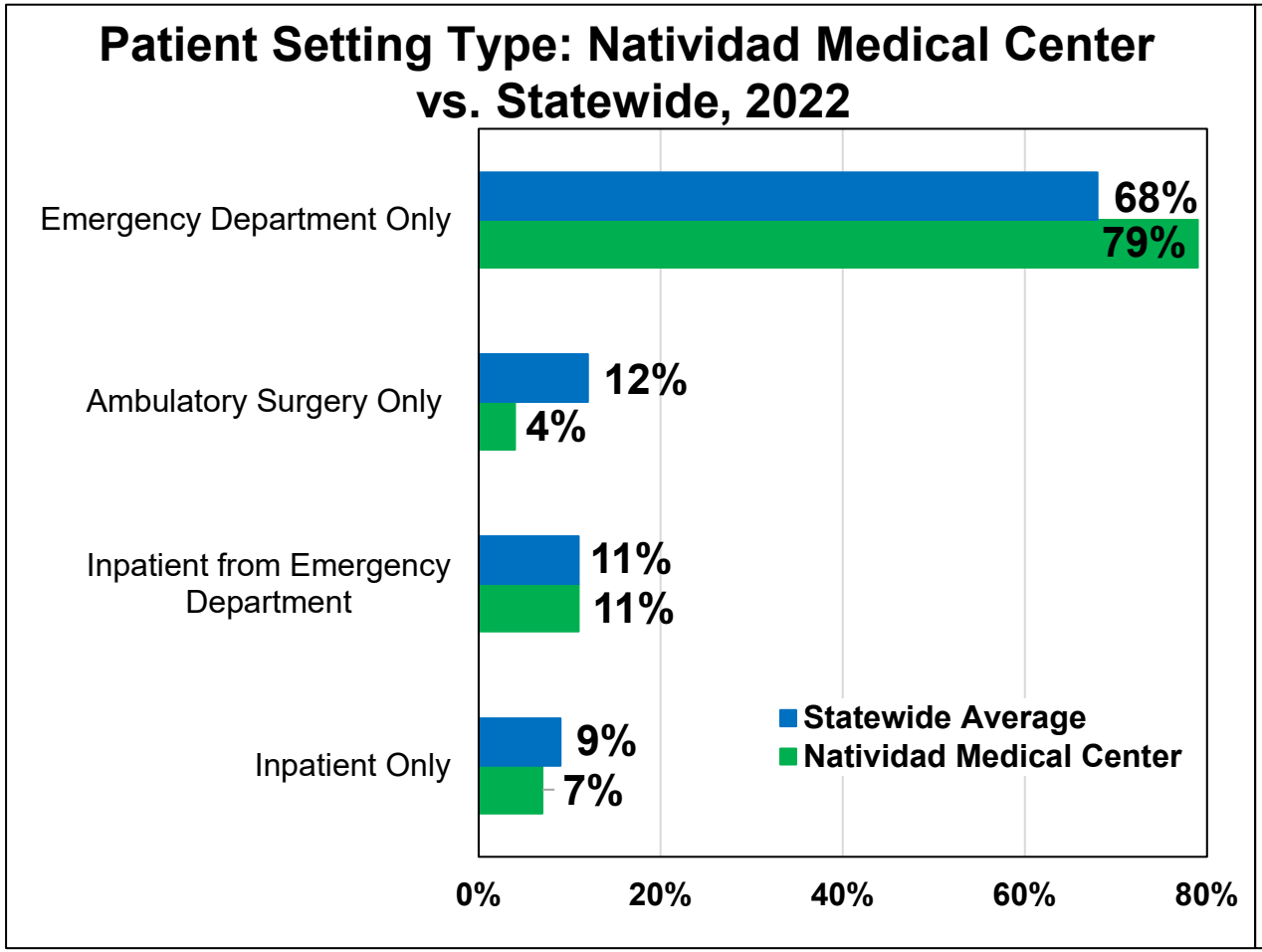


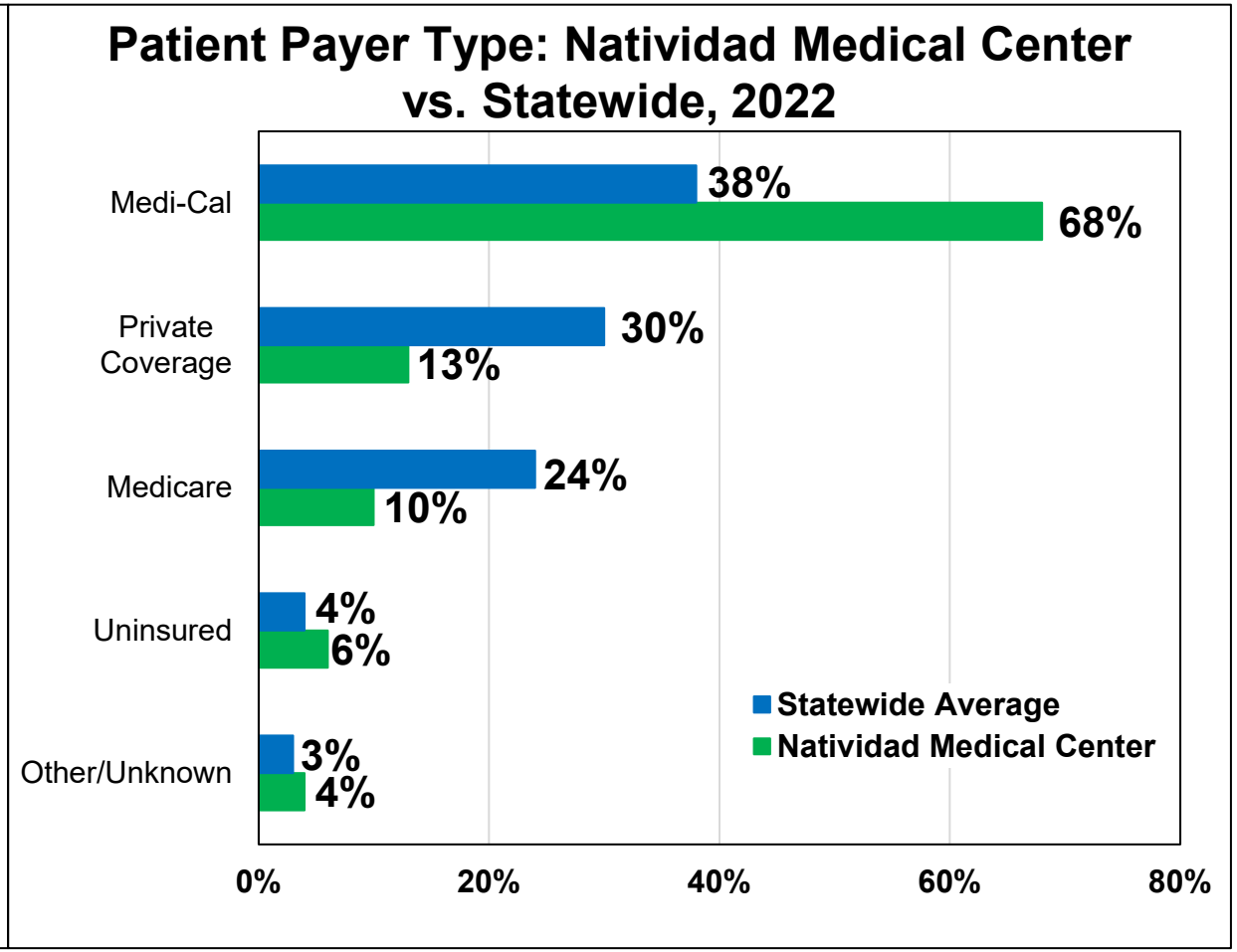


Source: HCAI Healthcare Utilization - Patient Level Administrative Data.

HCAI Department of Health Care Access and Information

Natividad vs. Statewide Average: Patient Setting Type and Payer Mix





Source: HCAI Healthcare Utilization - Patient Level Administrative Data.

HCAI Department of Health Care Access and Information

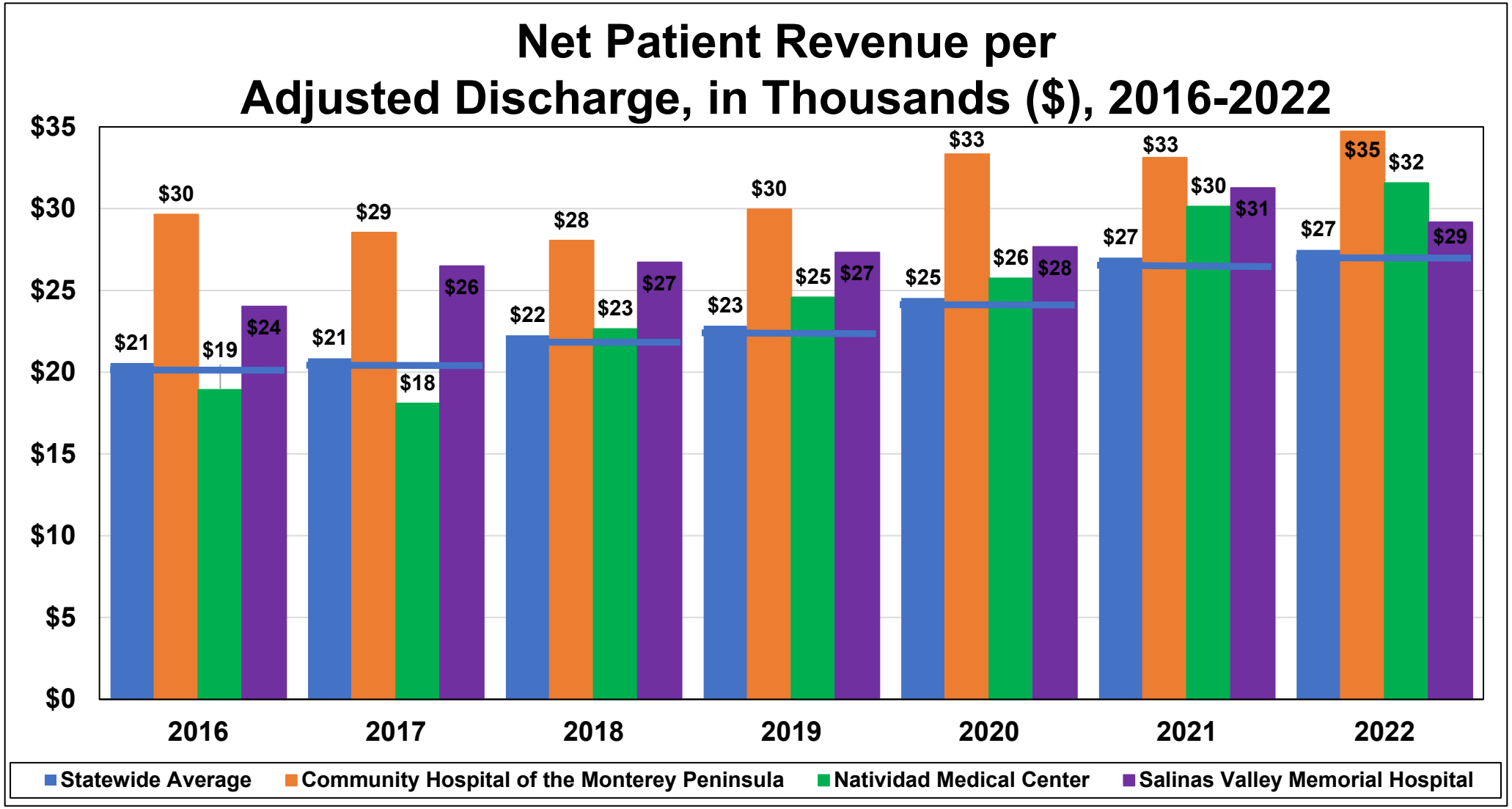
Hospital Price Metric

Hospital Prices in Monterey County

- Net Patient Revenues (NPR) refers to the amounts received by hospitals from payers and patients for the delivery of care.
- Based on HCAI Annual Financial Data, the NPR per adjusted discharge for CHOMP and Salinas Valley were consistently higher than the statewide average from 2016 through 2022.

Note: NPR payments includes Disproportionate Share Hospital payments and contractual adjustments. Medi-Cal supplemental payments are reported as credit to contractual adjustments (reduces deductions) and results in increased NPR (higher reimbursement).

Higher Payments Made to CHOMP & Salinas



Source: HCAI - Hospital Annual Financial Data, 2016 - 2022.

HCAI Department of Health Care Access and Information

Hospital Financial Metrics

Definitions

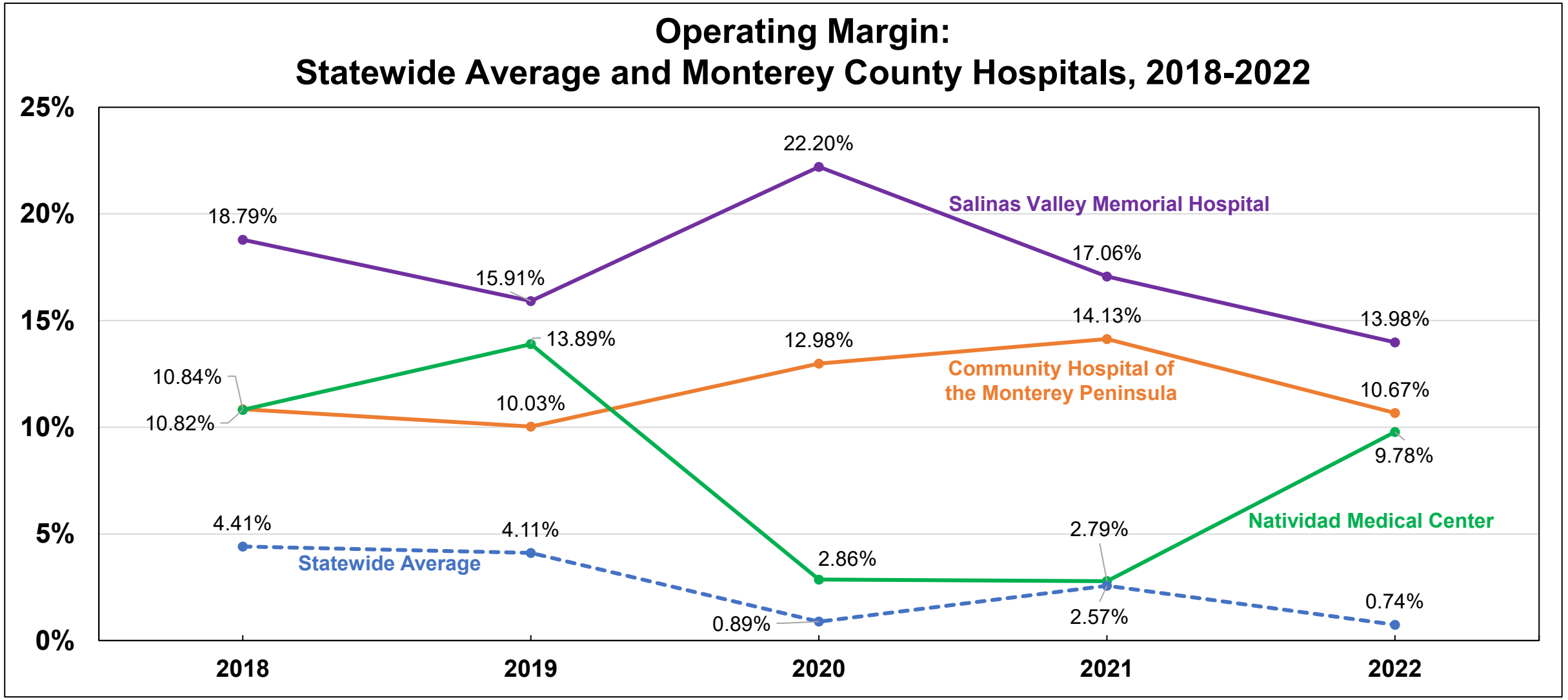
- **Operating Margin**: the net income from operations divided by total operating revenue (net patient revenue plus other operating revenue). This ratio indicates the percentage of net patient revenue which remains as income after operating expenses have been deducted.
- ***Charity Care Cost**: refers to the difference between the costs to the hospital for services provided to patients who are unable to pay for all or part of the services provided and the amount paid by or on behalf of the patient.
- ***Bad Debt**: the amount of care that was owed by the patient but not paid. It could be due to uninsured care or the patient's unpaid deductible/copay. (To be counted as bad debt, the patient also did not meet the eligibility criteria for charity care, according to the hospital. Individuals may claim they were not offered charity care, which as of January 1, 2024, can now be investigated by the HCAI Hospital Bill Complaint Program.)

* Charity Care Cost and Bad Debt have been converted to the cost to the hospital of providing the care using their cost-to-charge ratio, which is derived by subtracting other operating revenue from total operating expenses, then dividing the result by gross patient revenue. Cost-to-charge ratio is a methodology supported by the IRS for non-profit hospital's reporting on Schedule H of their required IRS Form 990 filing.

Hospital Financial Metrics for Monterey

- A review of HCAI Annual Hospital Financial Data finds Monterey County hospitals have positive operating margins, indicating profitability.
  - From 2018 to 2022, CHOMP and Salinas Valley Health had significantly higher operating margins than the statewide average.
- These profits are not associated with larger amounts of charity care provided.
  - Natividad and Salinas Valley Health have higher levels of bad debt.
  - CHOMP has a similar level of bad debt compared to the statewide average and a lower level of charity care provided.

Operating Margin



Source: HCAI - Hospital Annual Financial Data, 2018 - 2022.

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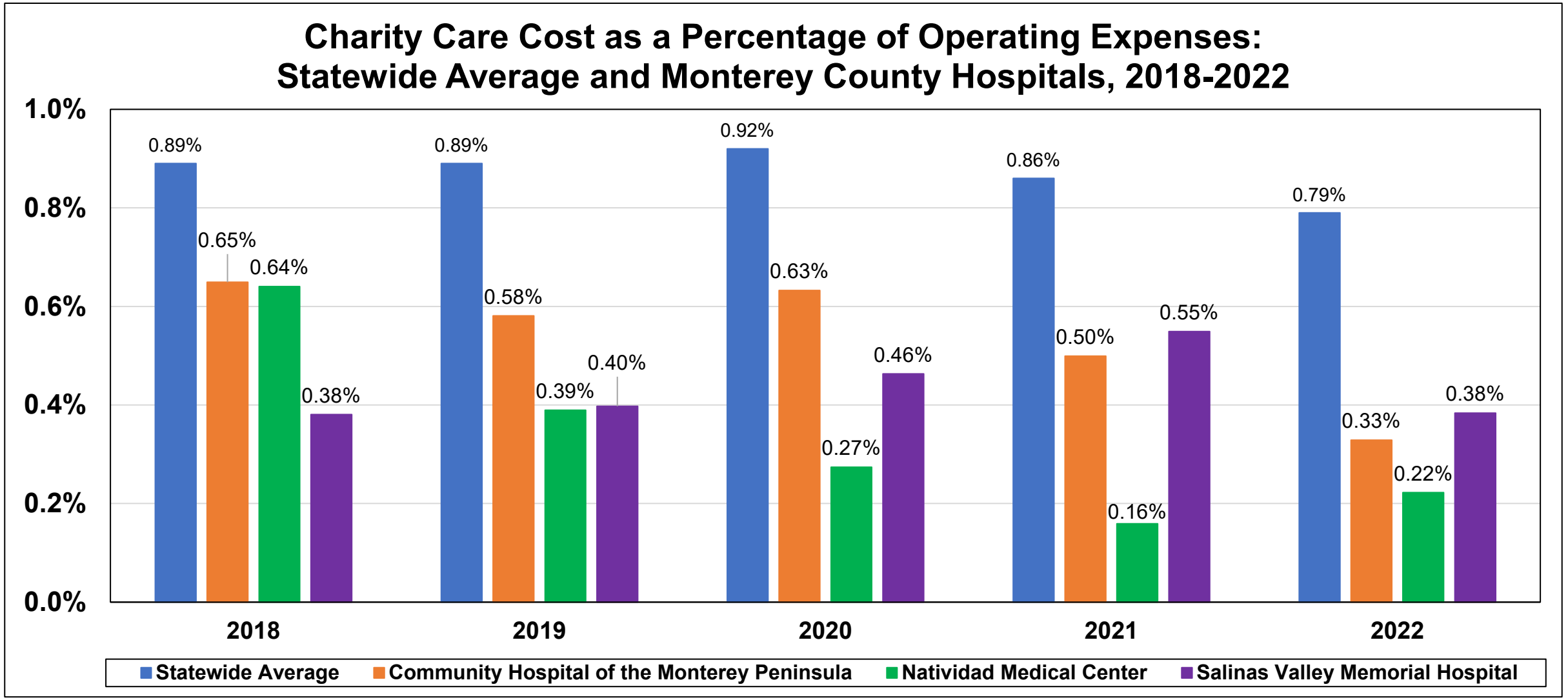
Charity Care



Source: HCAI - Hospital Annual Financial Data, 2018 - 2022.

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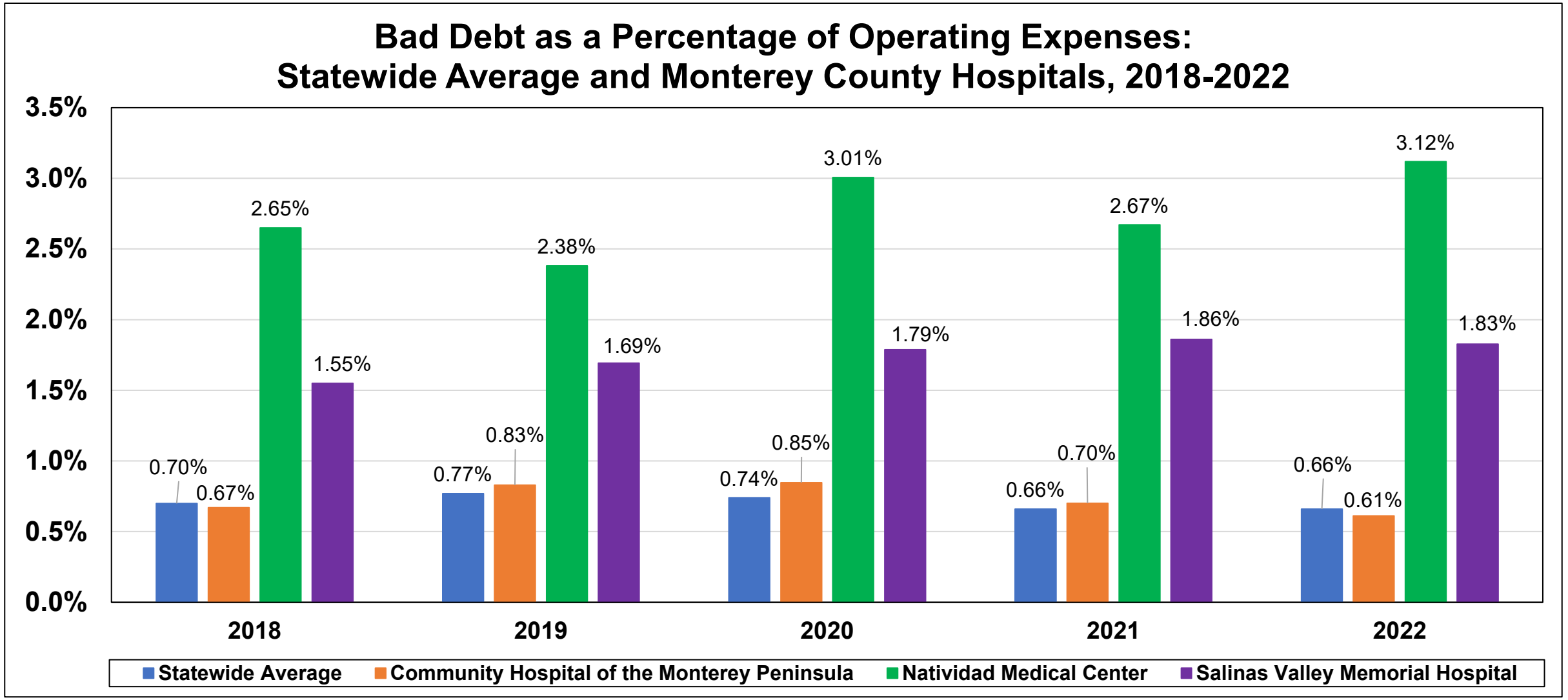
Bad Debt



Source: HCAI - Hospital Annual Financial Data, 2018 - 2022.

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Hospital Wage Metrics

Hospital Wage Metrics for Monterey County

Data Sources:

HCAI's average hourly wage and productive hours* data from 2018 to 2021 for the following hospital cost centers**:

- Registered Nurses (RNs)
  - Currently licensed from the California Board of Registered Nursing and employed in the performance of direct nursing care to patients.
  - Hours accounted for in the Daily Hospital Services cost centers.
  - Does not include contracted nurses.
- Nursing Administrators
  - Trained Registered Nurses who supervise nurses in the hospital including scheduling and transfer of nurses among the services and units, evaluation, and discipline.
  - Hours accounted for in the Nursing Administration cost center.
- Hospital Administrators
  - Plan, direct and coordinate all hospital services and manage supervisory staff.
  - Hours accounted for in the Hospital Administration cost center.

* Productive hours are paid time spent on tasks that support patient care.
**A cost center is a hospital overhead department that incurs costs but does not directly contribute to profit.
Source: HCAI - Hospital Annual Financial Data, 2018 - 2021.

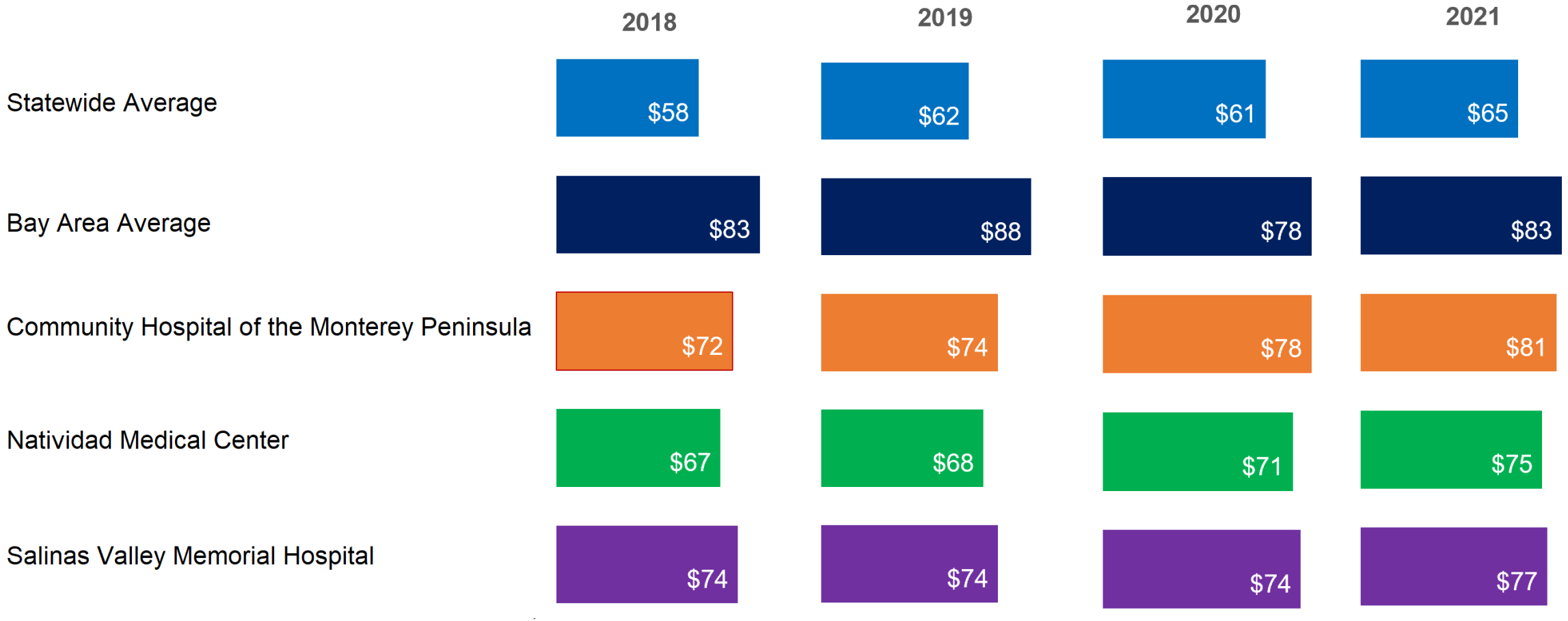
Hospital Wage Metrics for Monterey County

Findings from 2021:

- The hourly wage for Registered Nurses for all three Monterey County hospitals was above the statewide average and below the Bay Area average.
- The hourly wage for Nursing Administrators for all three Monterey County hospitals was above the statewide average.
  - CHOMP's and Salinas Valley Health's wage also exceeded the Bay Area average.
- The hourly wage for Hospital Administrators for CHOMP and Salinas Valley Health was above the statewide average.
  - CHOMP paid Hospital Administrators $183 per hour, a rate that is greater than the statewide and the Bay Area average by $75 and $67 per hour, respectively.

Hourly Wage for Registered Nurses

Hourly Rate of Registered Nurses (RNs): Statewide Average, Bay Area Average, and Monterey County Hospitals, 2018-2021



Registered Nurses includes nurses employed in the performance of direct nursing care to patients. Salaries and wages is defined as all remuneration for services performed by an employee for the hospital employer payable in cash; and the fair market value of services donated to the hospital by persons performing under an employee relationship. Excludes reimbursement of independent contractors such as Private Duty Nurses.
Source: HCAI - Hospital Annual Financial Data, 2018 - 2021.

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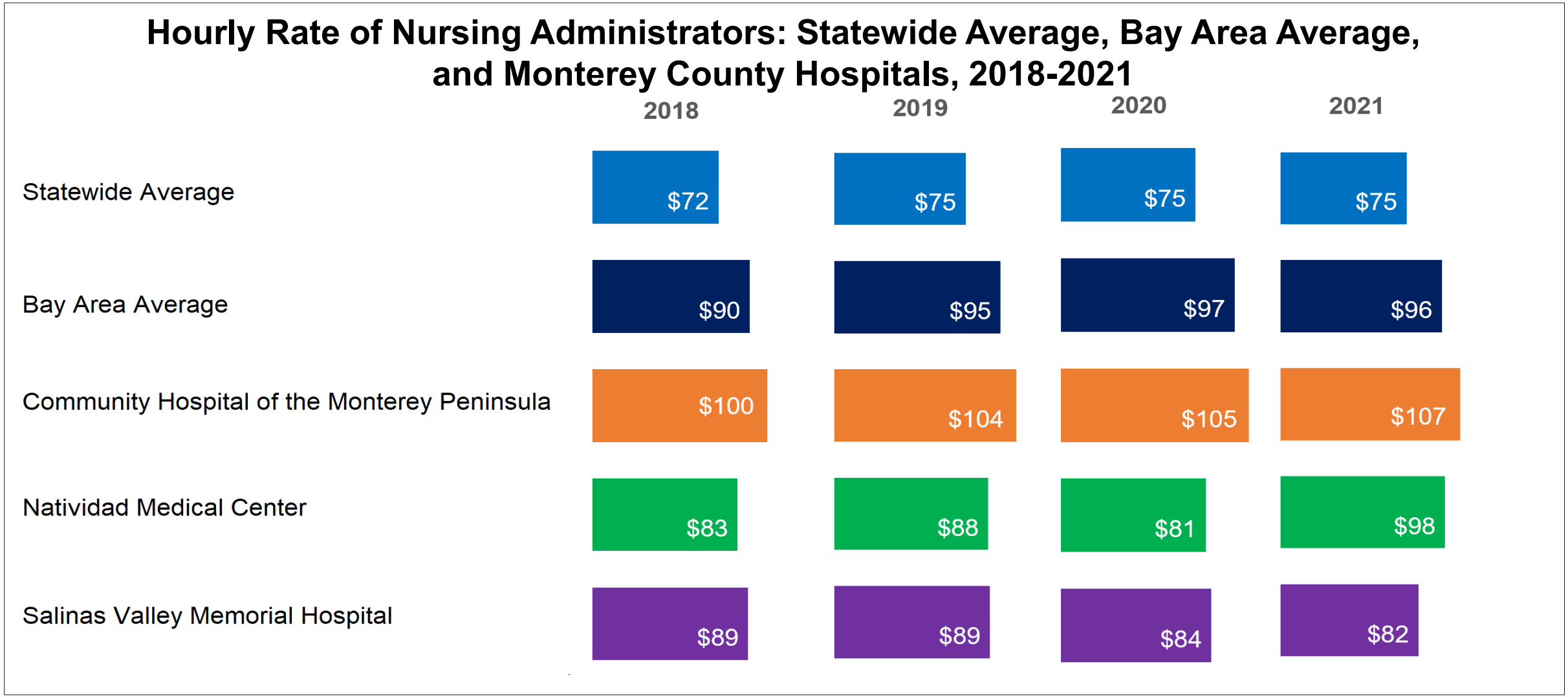
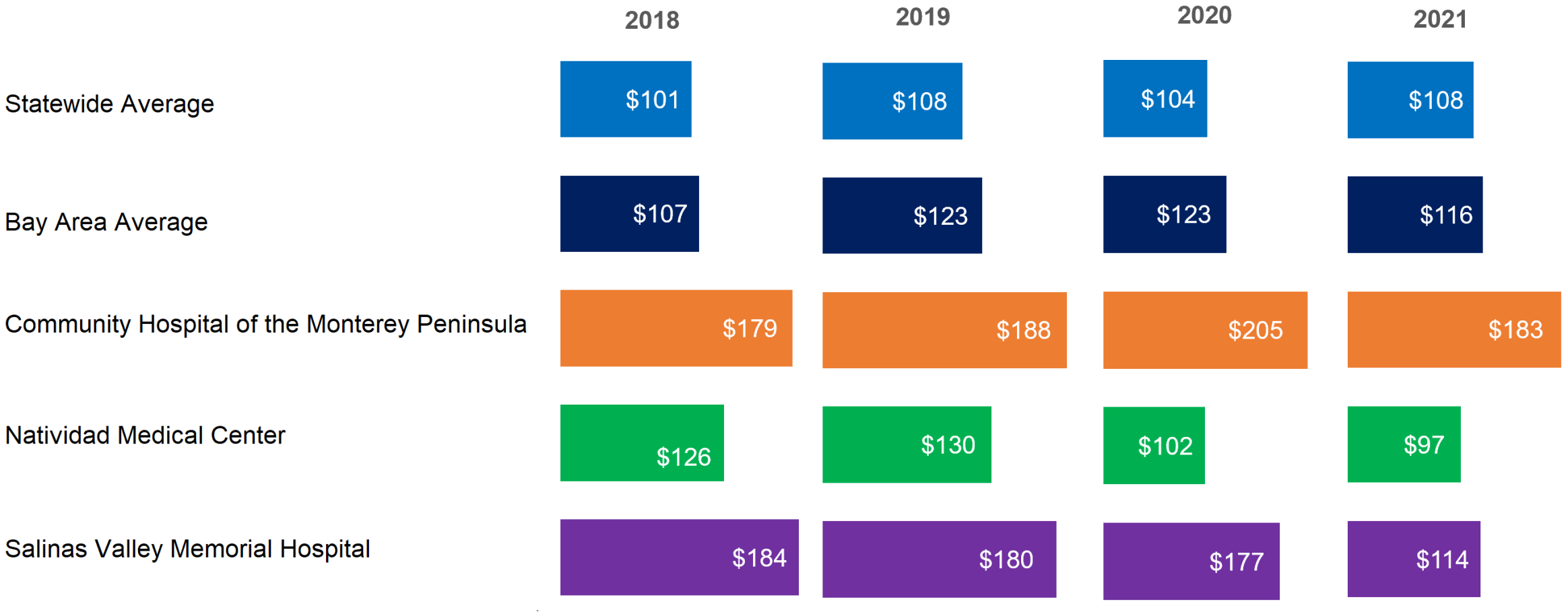
Hourly Wage for Nursing Administrators



Nursing Administrators perform the administration and supervision of nurses in the hospital including scheduling and transfer of nurses among the services and units, nursing staff supervision, evaluation, and discipline. Salaries and wages is defined as all remuneration for services performed by an employee for the hospital employer payable in cash; and the fair market value of services donated to the hospital by persons performing under an employee relationship.
Source: HCAI - Hospital Annual Financial Data, 2018 - 2021.

Hourly Wage for Hospital Administrators

Hourly Rate of Hospital Administrators: Statewide Average, Bay Area Average, and Monterey County Hospitals, 2018-2021



Hospital Administrators perform overall management and administration of the institution. Salaries and wages is defined as all remuneration for services performed by an employee for the hospital employer payable in cash; and the fair market value of services donated to the hospital by persons performing under an employee relationship.
Source: HCAI - Hospital Annual Financial Data, 2018 - 2021.

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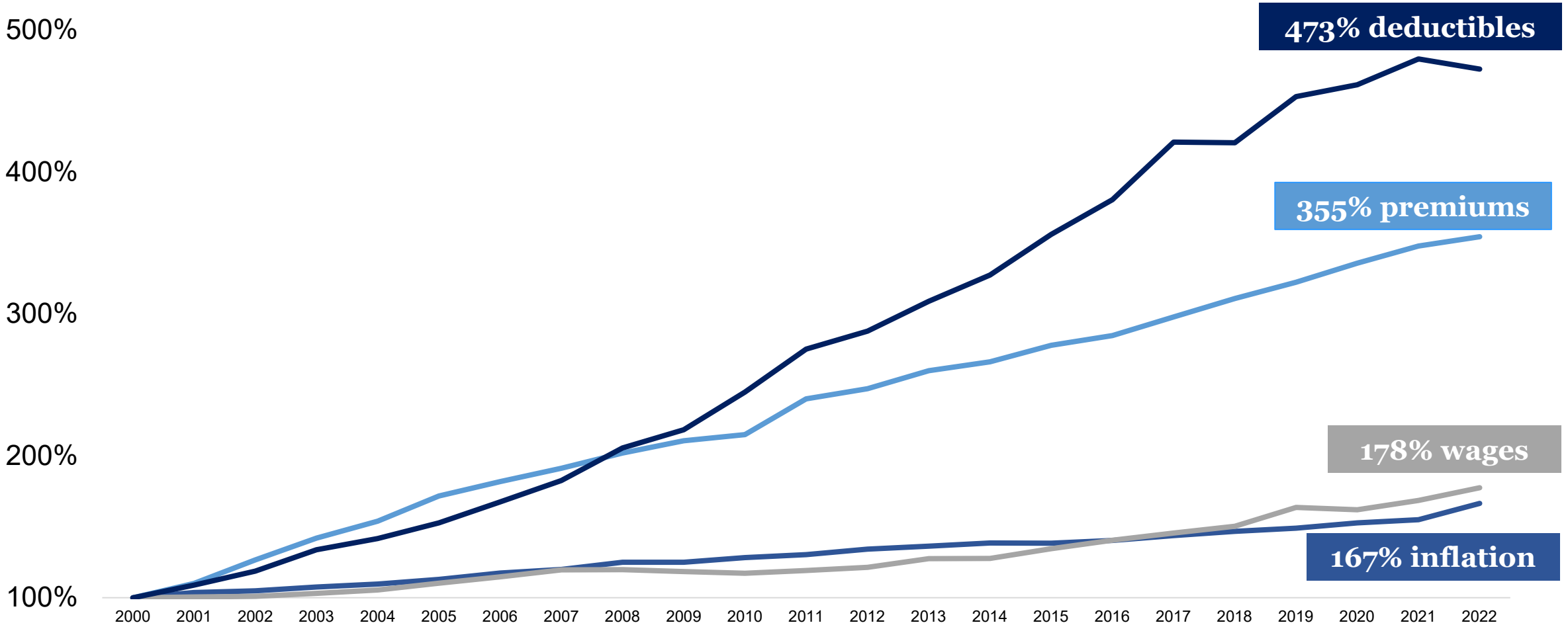
Examining Monterey-Area Hospital Prices

August 2024

Christopher Whaley, PhD
Brown University School of Public Health

Premiums and deductibles have outpaced worker wages

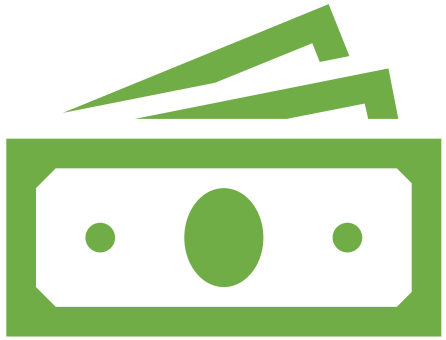


Source: National data from the Federal Reserve Economic Data, KFF, and Medical Expenditure Panel Survey

Hospital Price Transparency Study: Round 5

Obtain claims data from

- self-funded employers
- APCDs
- health plans



Measure prices in two ways

- relative to a Medicare benchmark
- price per case-mix weight

Create a *public* hospital price report

- posted online, downloadable
- named facilities & systems
- inpatient prices & outpatient prices
- Sage Transparency dashboard

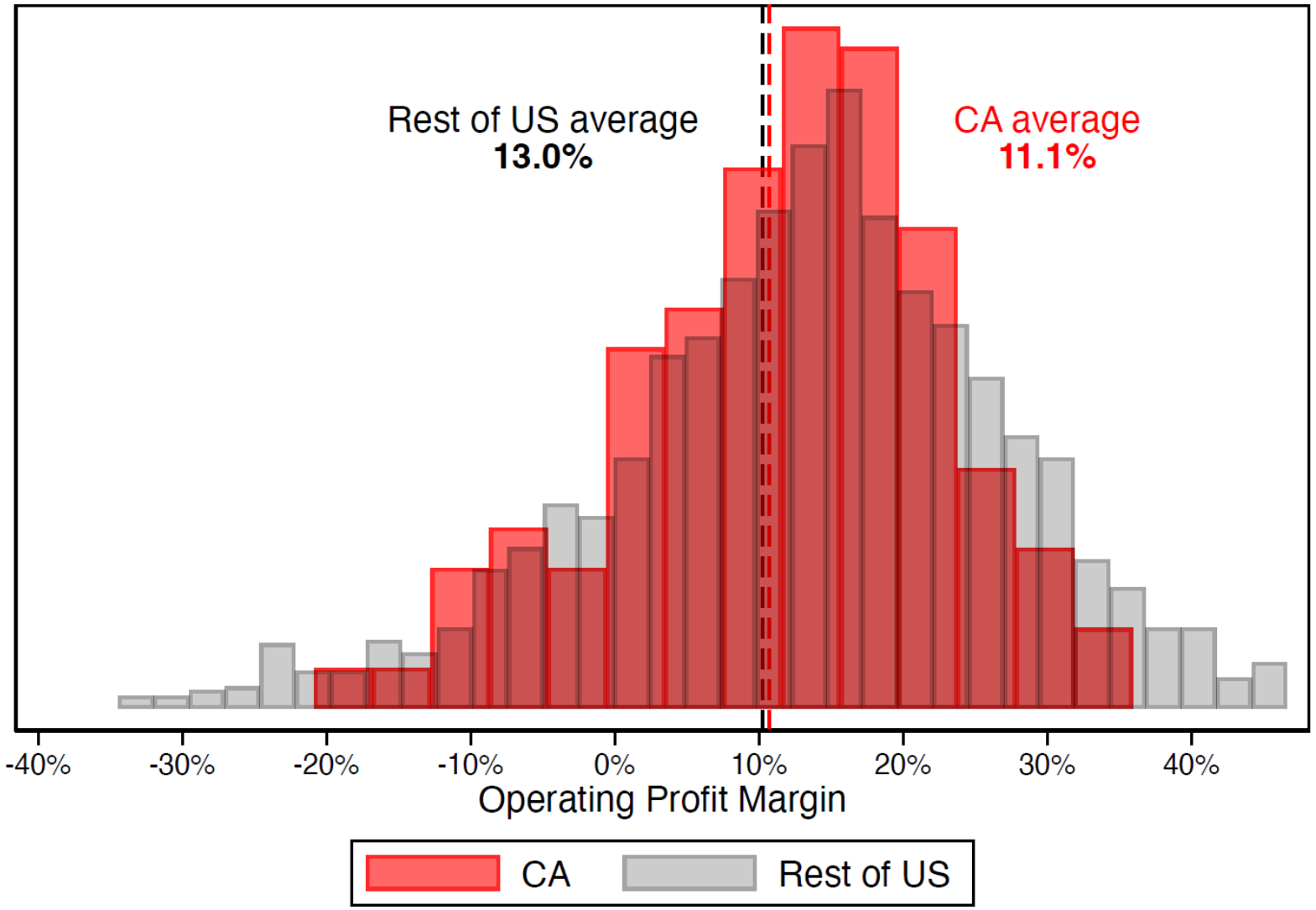
Percent of Medicare is a price benchmark, not a price endpoint

- Benchmarking to Medicare allows employers to compare prices between hospitals, relative to the largest purchaser in the world

- Medicare prices and methods are empirically based and transparent

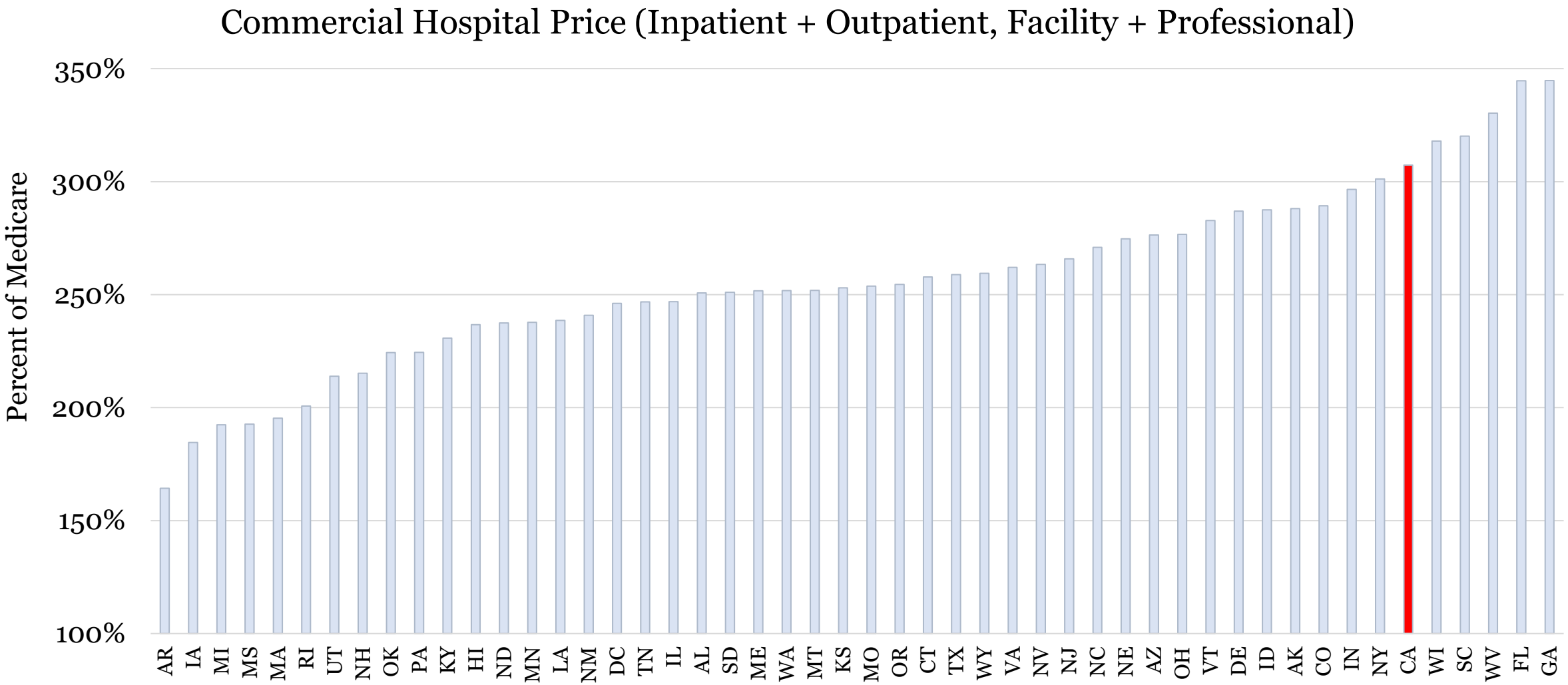
- **Medicare Payment Advisory Commission (MedPAC)**: Medicare rates are close to break-even for efficient hospitals

California hospital margins are close to the national average



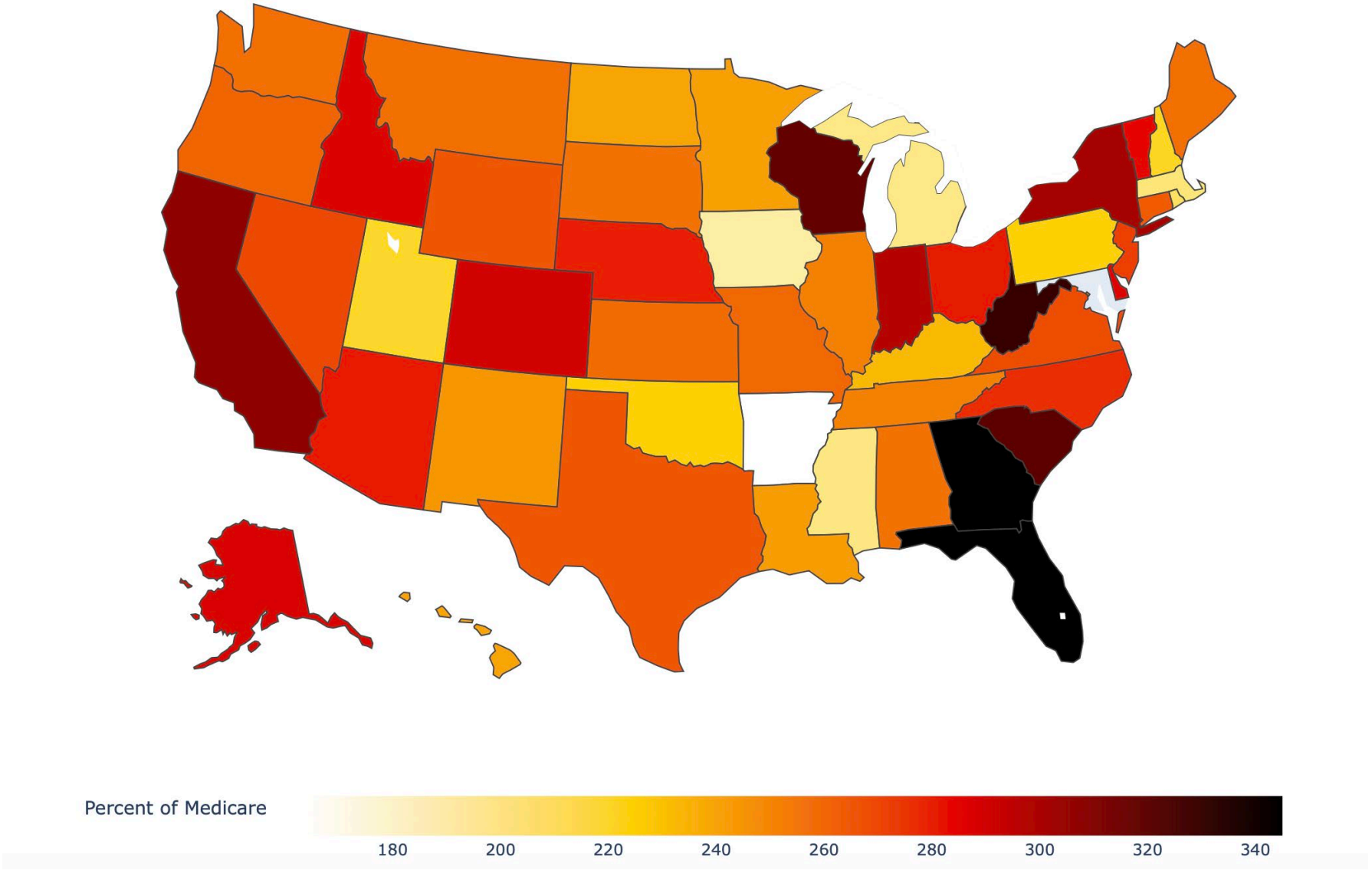
Source: CMS Cost Report Data, 2022. Excludes Critical Access Hospitals

Hospital commercial insurance prices are high and variable



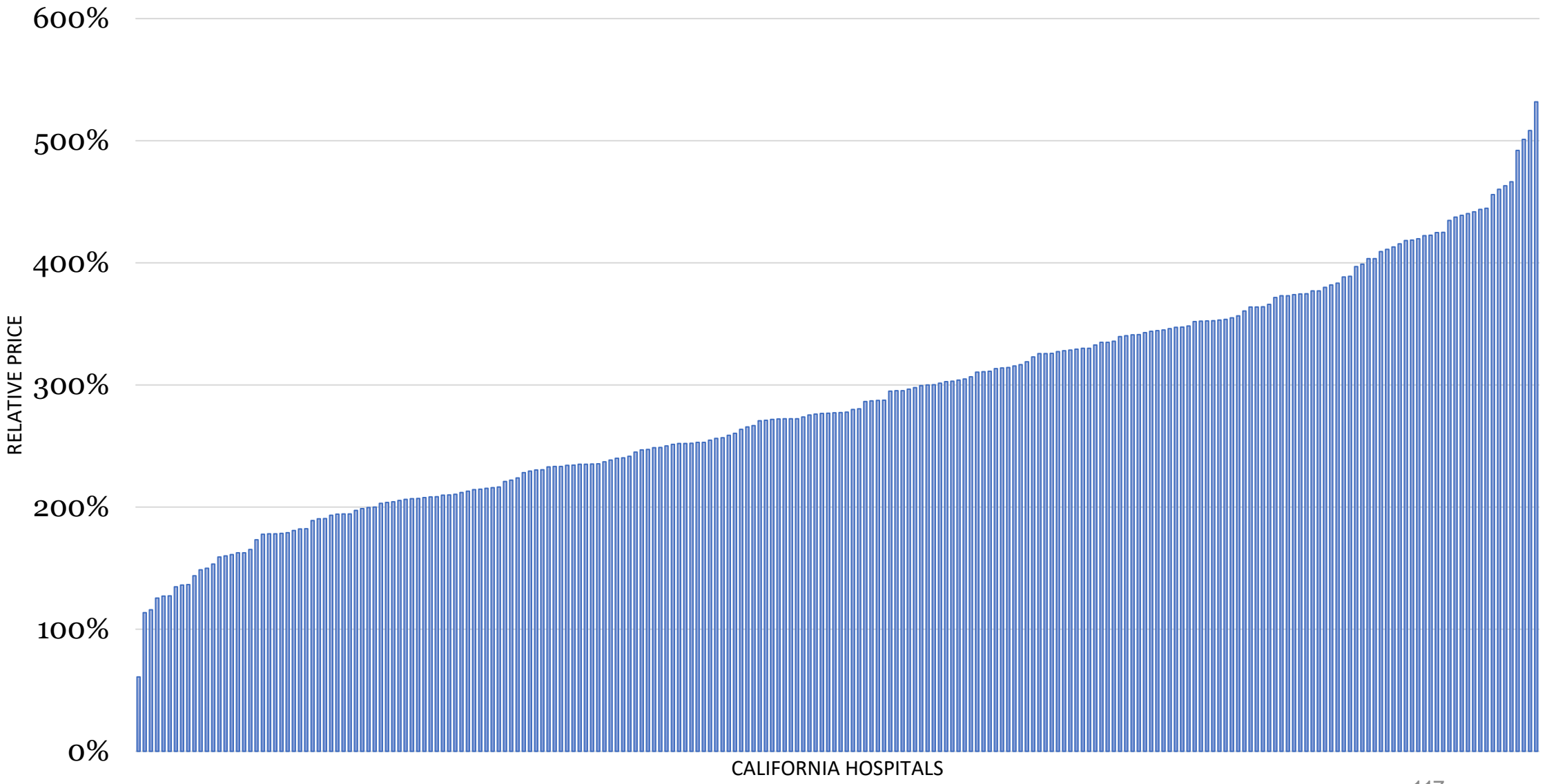
Source: Prices Paid to Hospitals by Private Health Plans: Findings from Round 5 of an Employer-Led Transparency Initiative. Whaley et al. RAND. 2024

Hospital prices are all over the map



Source: Prices Paid to Hospitals by Private Health Plans: Findings from Round 5 of an Employer-Led Transparency Initiative. Whaley et al. RAND. 2024

Over 5x variation in California hospital prices



Source: Analysis of Prices Paid to Hospitals by Private Health Plans data. Whaley et al. 2024

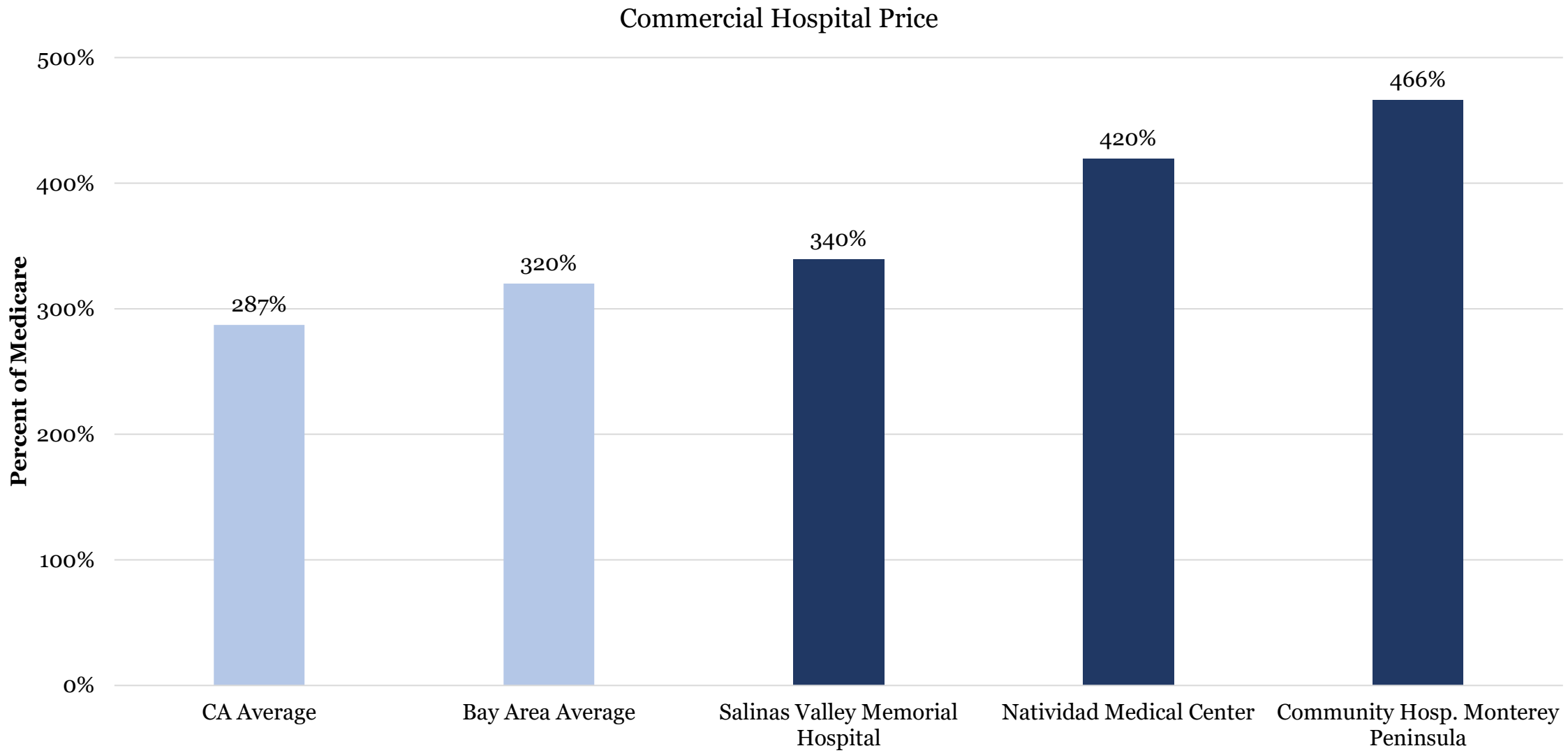
Monterey-area hospital price comparison approach

Compare Monterey area hospitals with California and Bay Area prices

- Monterey hospitals:
  - Salinas Valley Memorial Hospital
  - Natividad Medical Center
  - Community Hosp. Monterey Peninsula

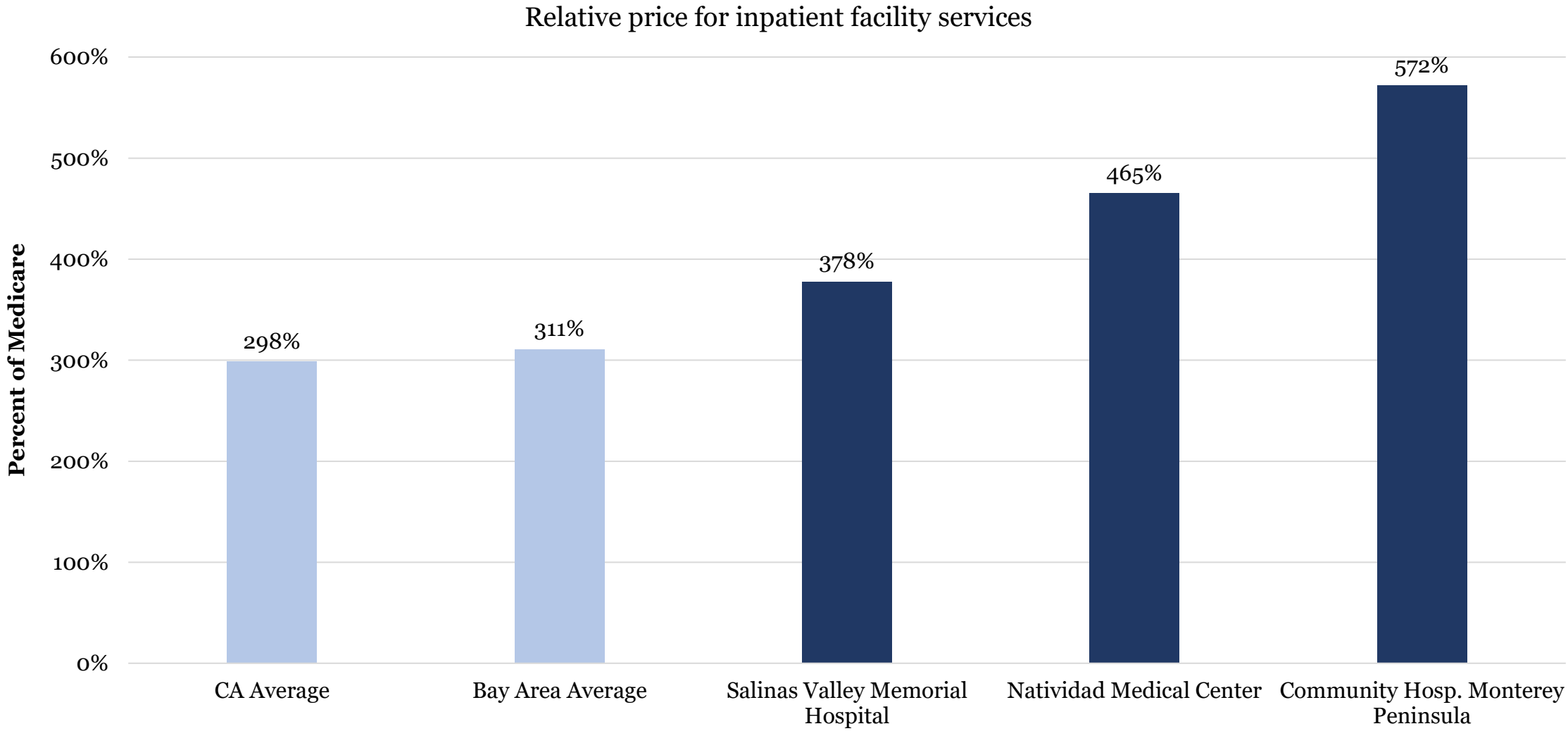
- Bay Area peer hospital markets:
  - Alameda County
  - Contra Costa County
  - Napa
  - San Francisco
  - San Jose
  - San Mateo County
  - Santa Cruz
  - Santa Rosa

Monterey-area hospital prices are above peers



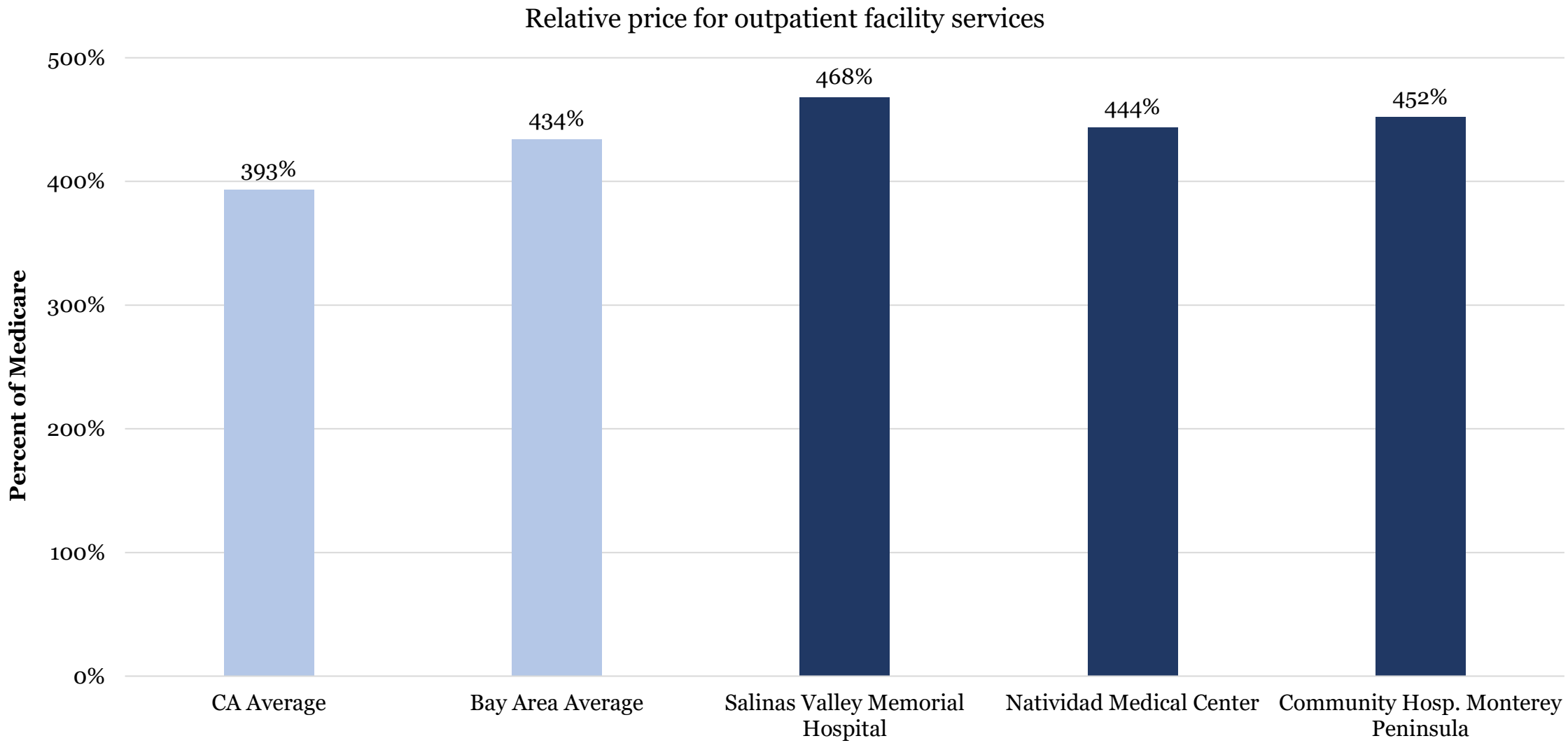
Source: Analysis of Prices Paid to Hospitals by Private Health Plans data. Whaley et al. 2024

Monterey-area hospitals have higher inpatient prices



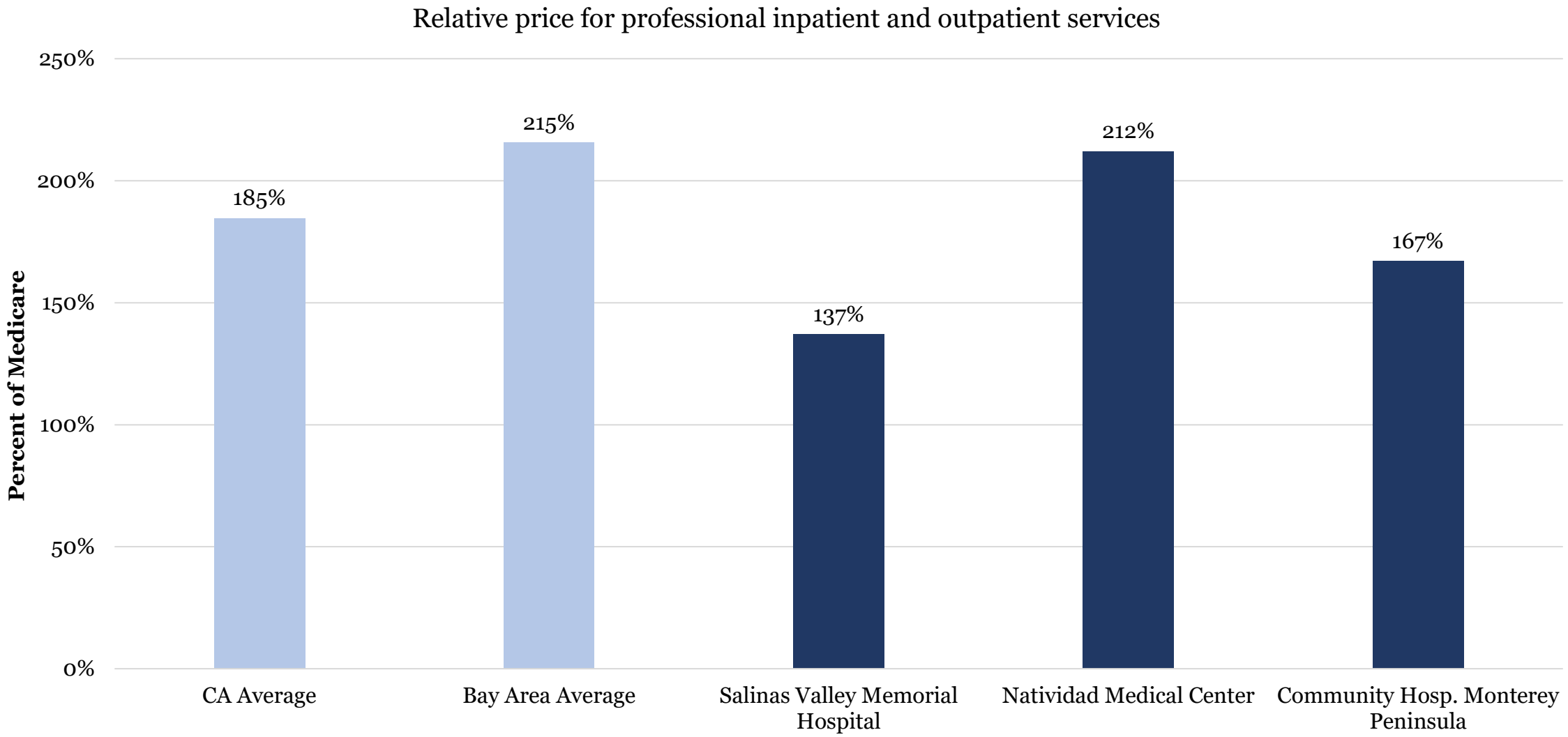
Source: Analysis of Prices Paid to Hospitals by Private Health Plans data. Whaley et al. 2024

Monterey-area hospitals have higher outpatient prices



Source: Analysis of Prices Paid to Hospitals by Private Health Plans data. Whaley et al. 2024

Monterey-area hospitals have lower professional prices



Source: Analysis of Prices Paid to Hospitals by Private Health Plans data. Whaley et al. 2024

What drives prices?

No correlation with Medicare, Medicaid, or uncompensated patients ("cost shifting" not true)

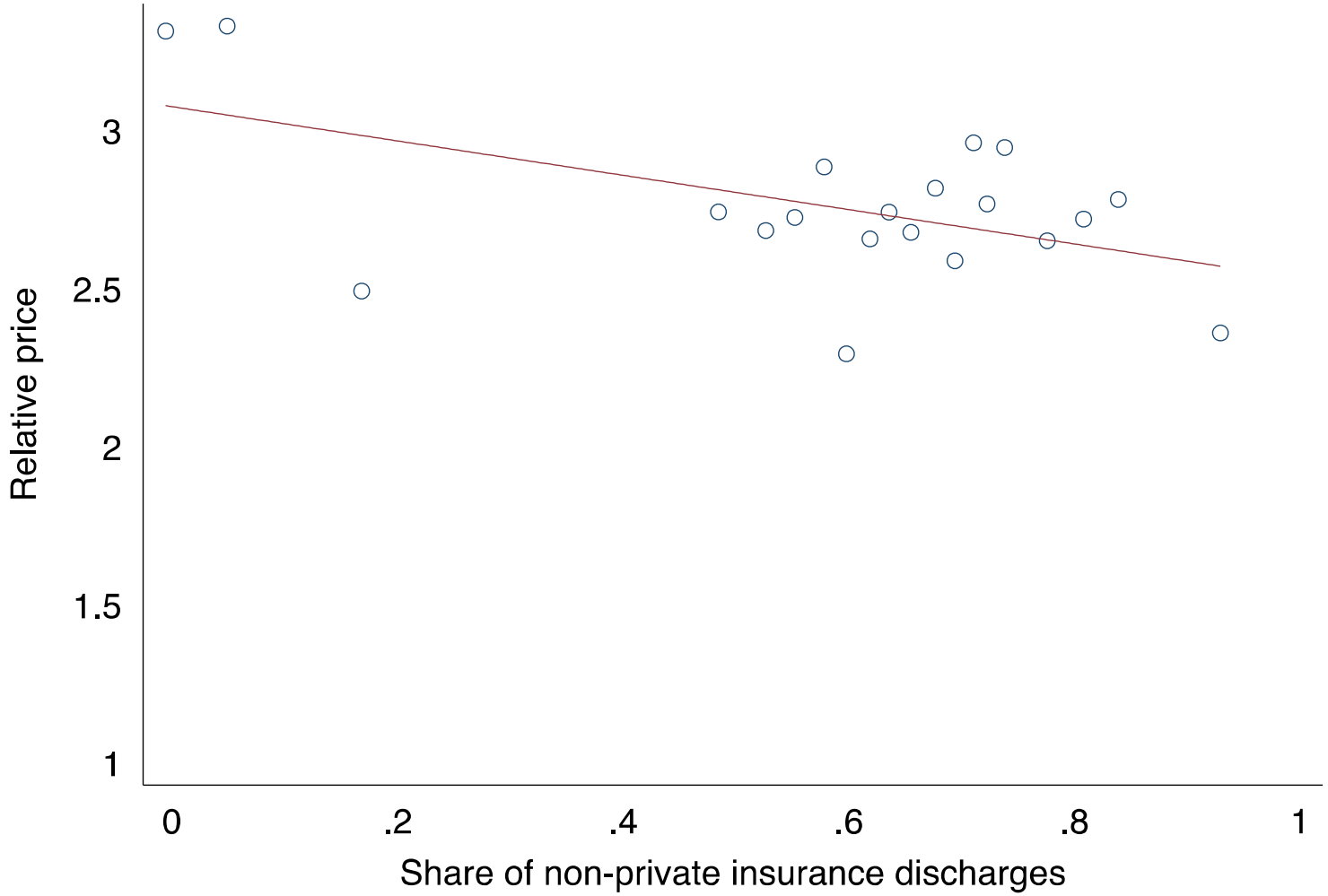
Minimal correlation with quality and outcomes

Strong correlation with market power and concentration

Cost-shifting doesn't explain California hospital prices

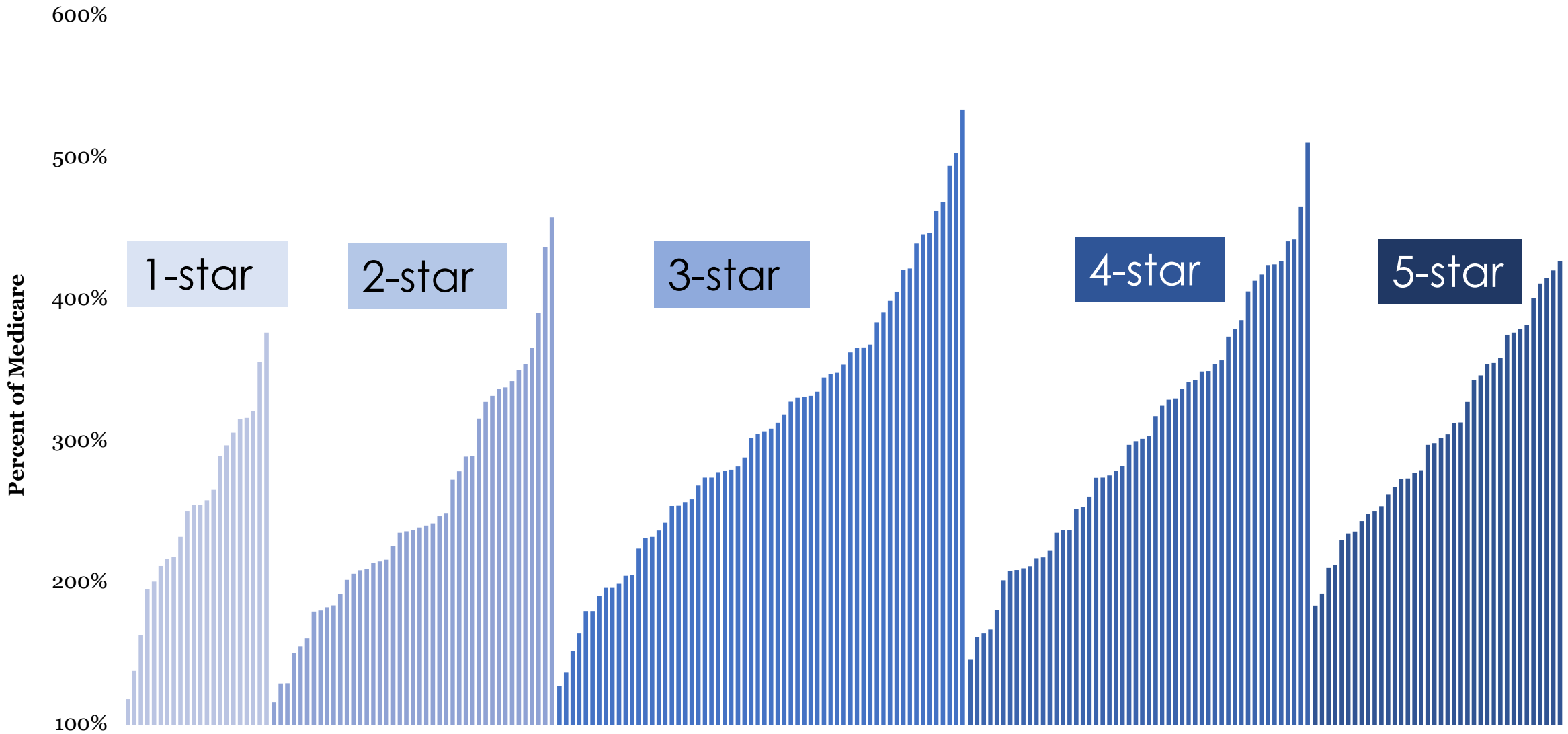
Contrary to cost-shifting, ***CA hospitals with more publicly-insured patients have lower prices*** vs. hospitals with mainly private patients

10% point increase in non—private patients associated with statistically significant 5.4% point lower prices



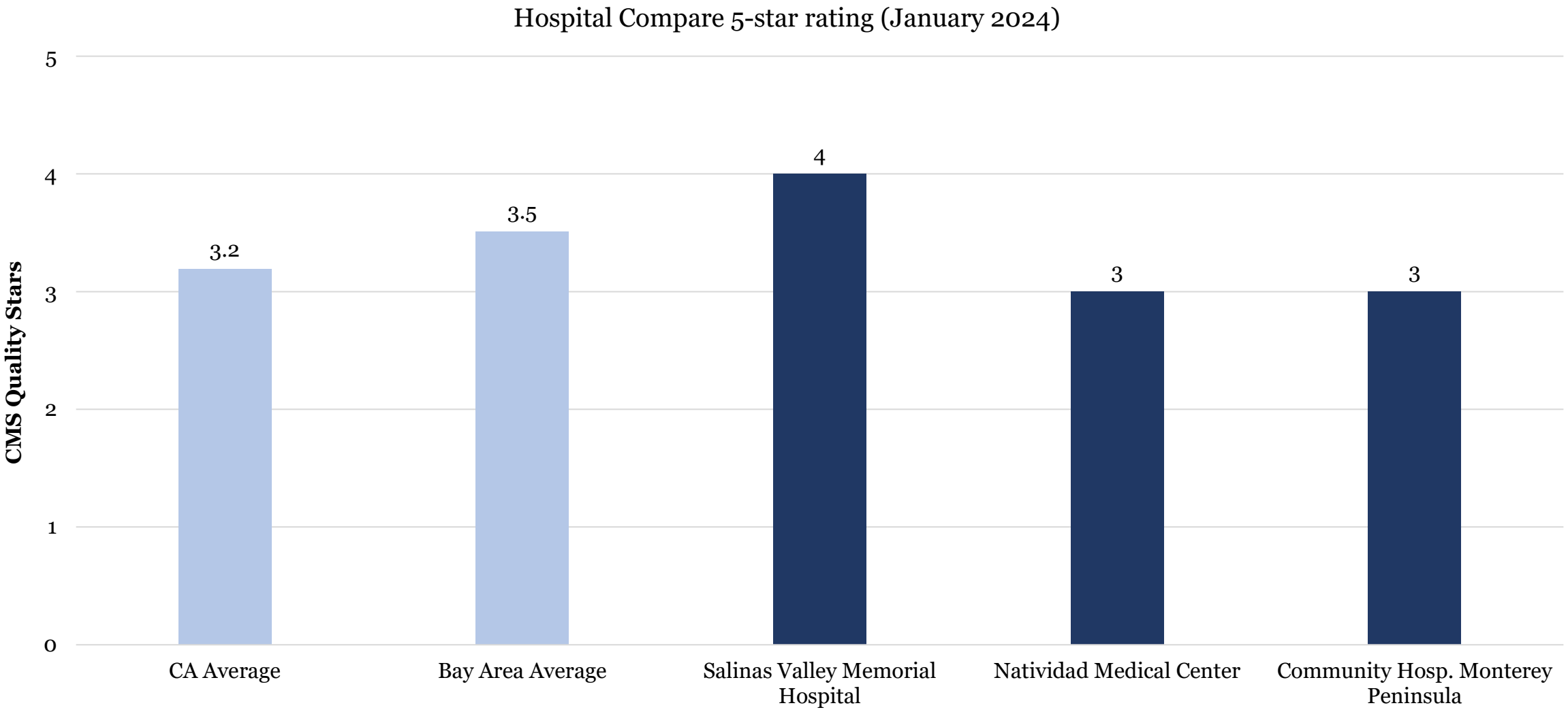
Source: Analysis of Prices Paid to Hospitals by Private Health Plans data. Whaley et al. 2024

5x variation in California hospital prices is not linked to CMS quality stars



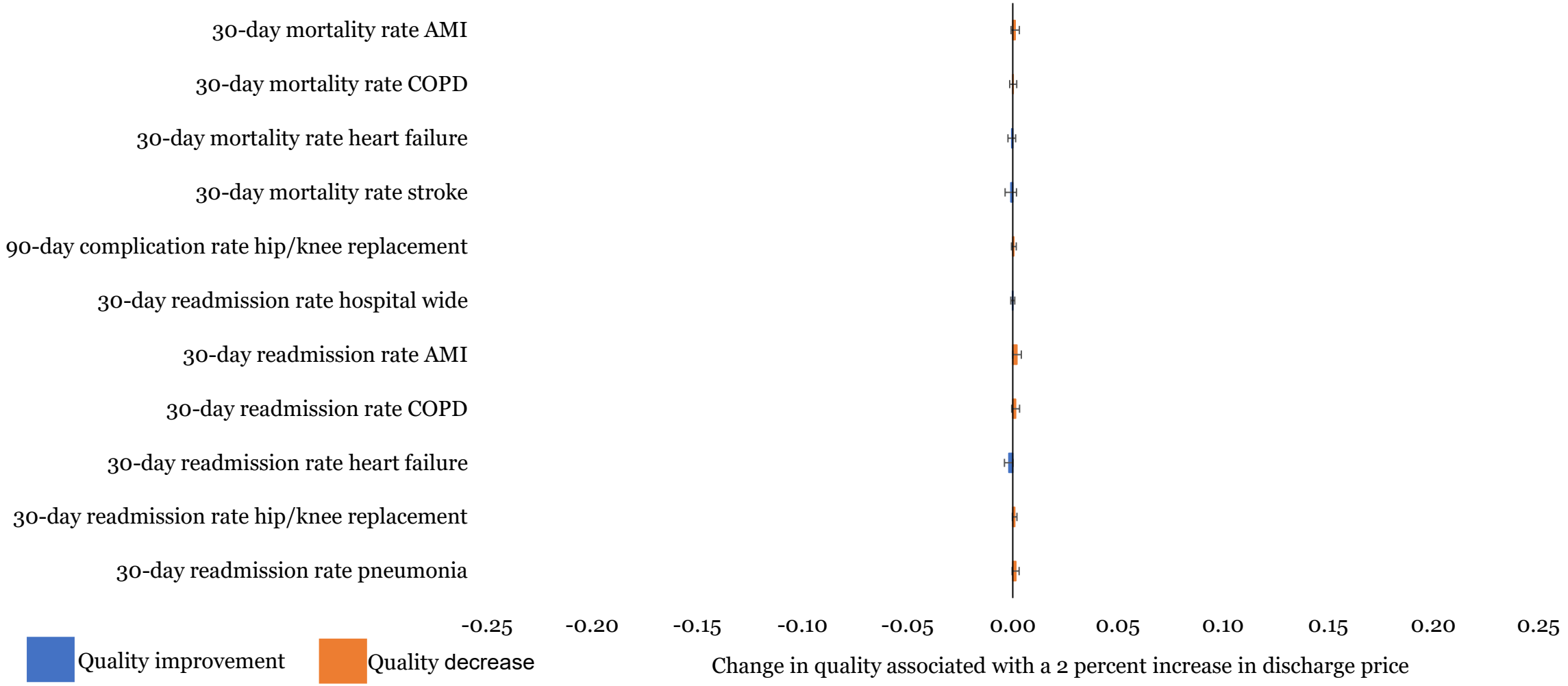
Source: Analysis of Prices Paid to Hospitals by Private Health Plans data. Whaley et al. 2024

Monterey-area hospitals have similar CMS quality scores as peers



Source: Analysis of Prices Paid to Hospitals by Private Health Plans data. Whaley et al. 2024

Hospital price increases don't lead to clinical quality improvements

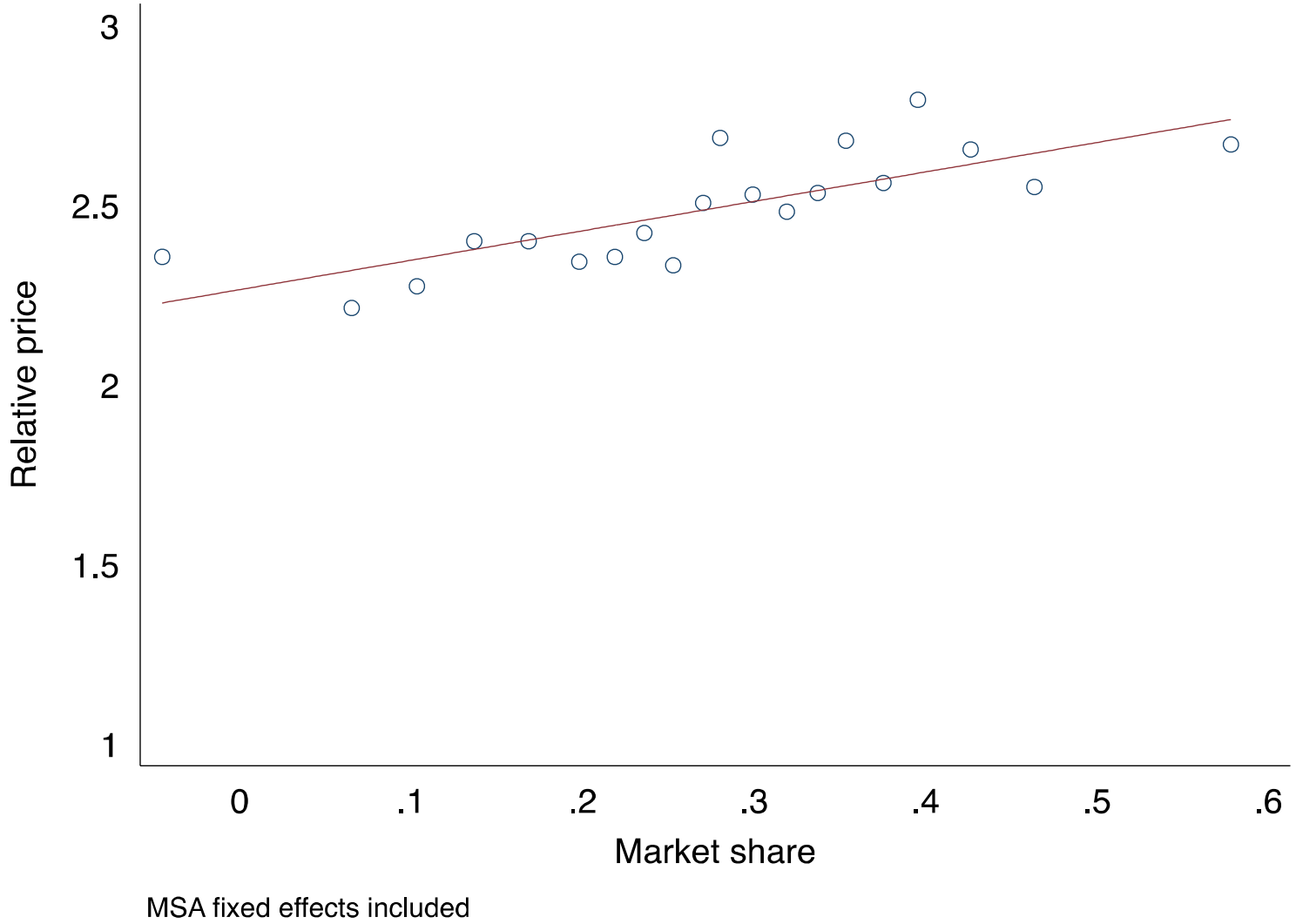


Source: Crespin and Whaley. 2022. "The Effect of Hospital Discharge Price Increases on Publicly Reported Measures of Quality." *Health Services Research*.

Market concentration drives California prices

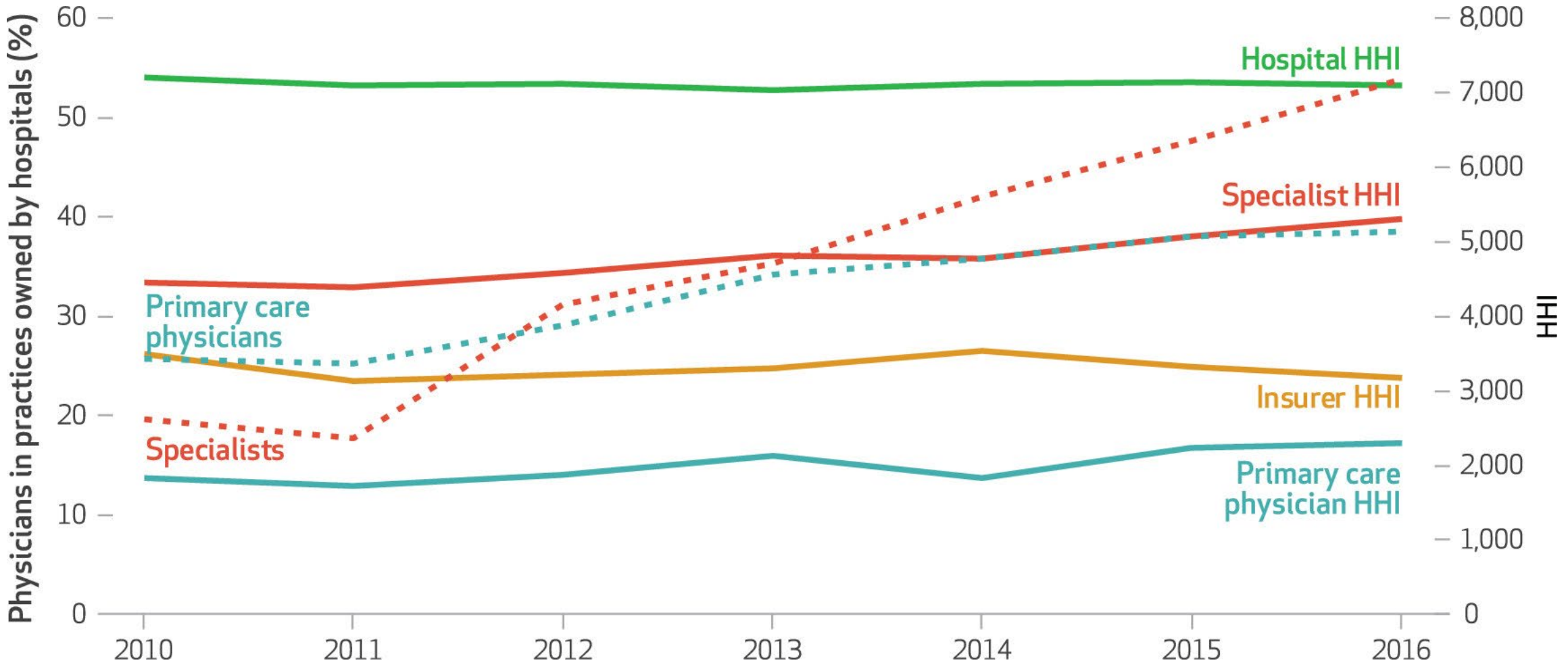
CA hospitals with more market share have higher prices vs. hospitals with lower market share

10% point increase in non—private patients associated with statistically significant 25% point higher prices



Source: Analysis of Prices Paid to Hospitals by Private Health Plans data. Whaley et al. 2024

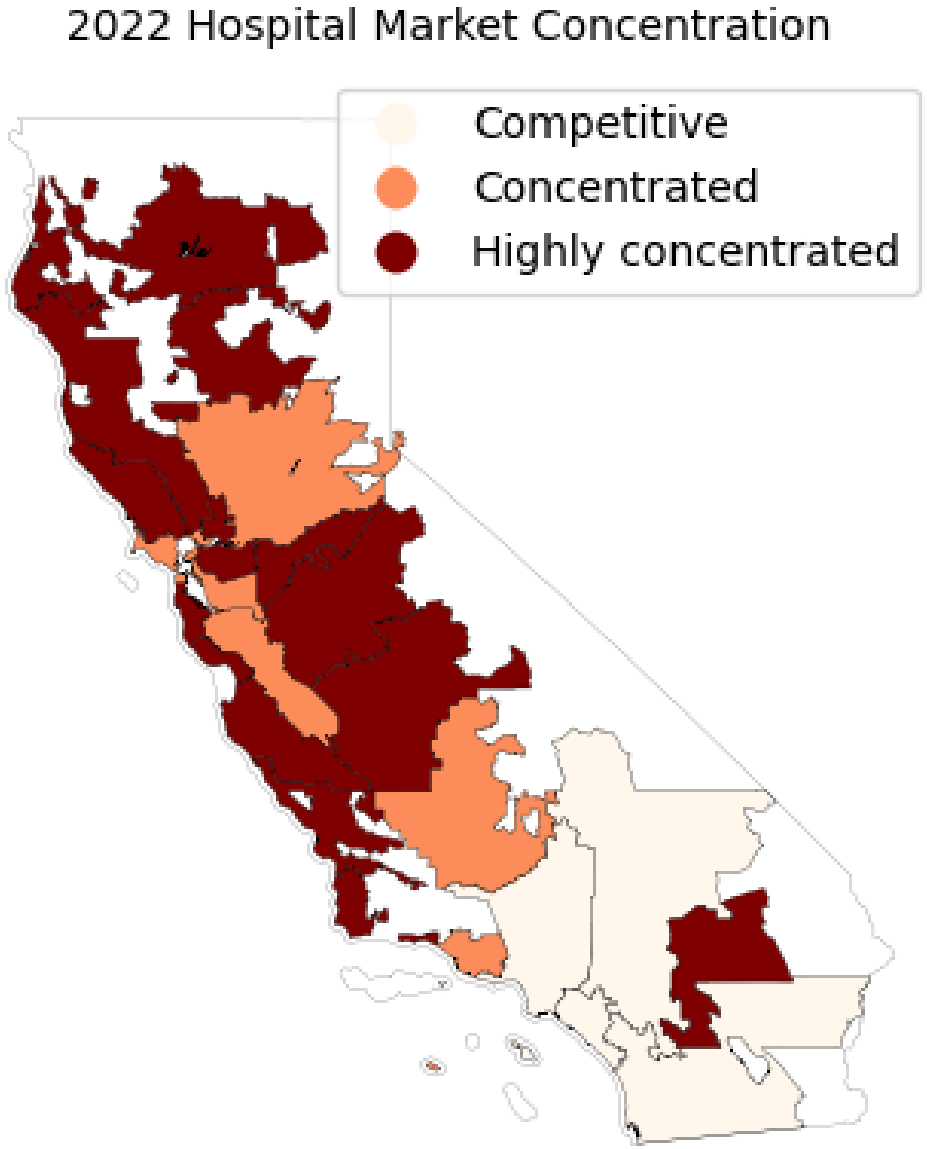
California provider markets are consolidated



HHI = Herfindahl–Hirschman Index, a measure used to measure market competition with HHIs above 1,800 indicating highly concentrated markets and HHIs of 10,000 indicating monopoly markets

Source: Consolidation Trends In California's Health Care System: Impacts On ACA Premiums And Outpatient Visit Prices. Richard Scheffler, et al. Health Affairs 2018

Northern and Central California hospital markets are highly concentrated

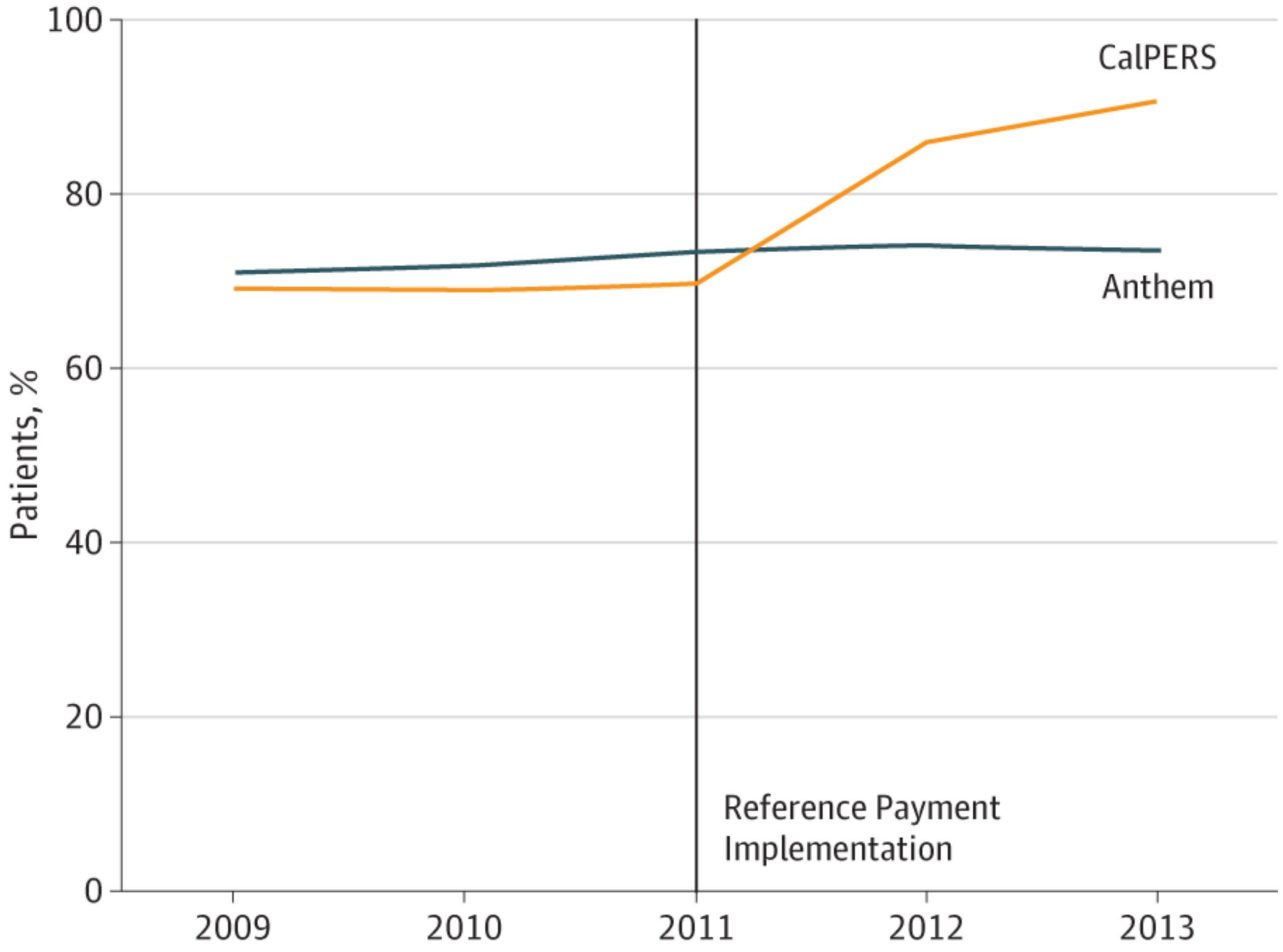


What is the road ahead?

- Hospital prices are high and variable, largely due to market concentration

- Policy and regulators have been slow to act, but are finally moving
  - Oregon: ownership disclosure
  - Texas: anti-competitive contract provision bans
  - Federal Trade Commission actions on non-competes, consolidation, and private equity
  - Medicare site-neutral payment policies

CalPERS saves money by increasing use of Ambulatory Surgical Centers (ASCs)



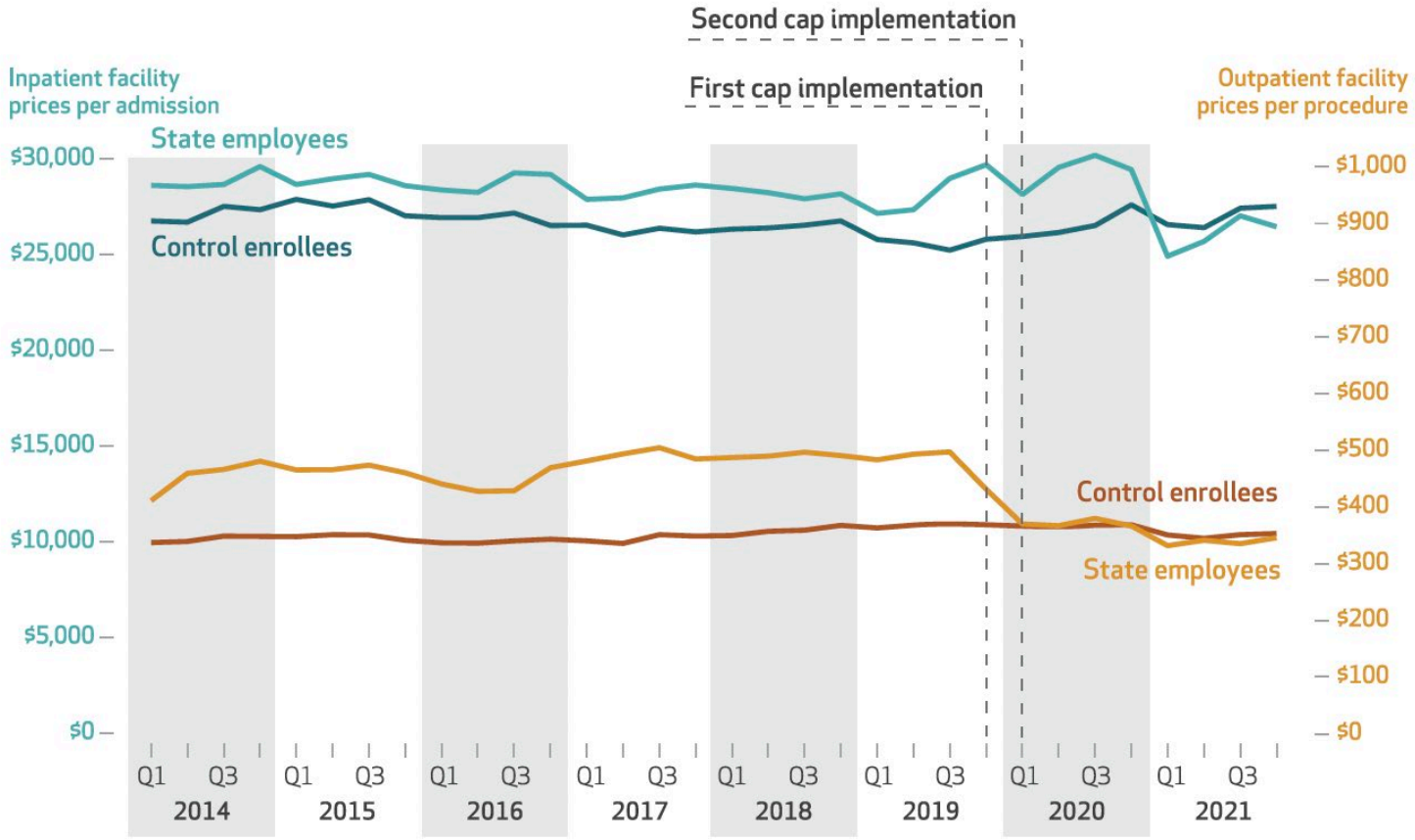
- Targeted financial incentives to use ASCs vs. Hospital Outpatient Departments
- Approximately 20% savings on range of shoppable services
- Improvements in quality outcomes

Source: Robinson, Brown, Whaley (2017) *Health Affairs*

Capping Prices: Reference-based pricing saves money

EXHIBIT 1

Average hospital facility prices per admission (inpatient) or procedure (outpatient) for Oregon state employee plan enrollees versus control enrollees, by quarter, 2014–21



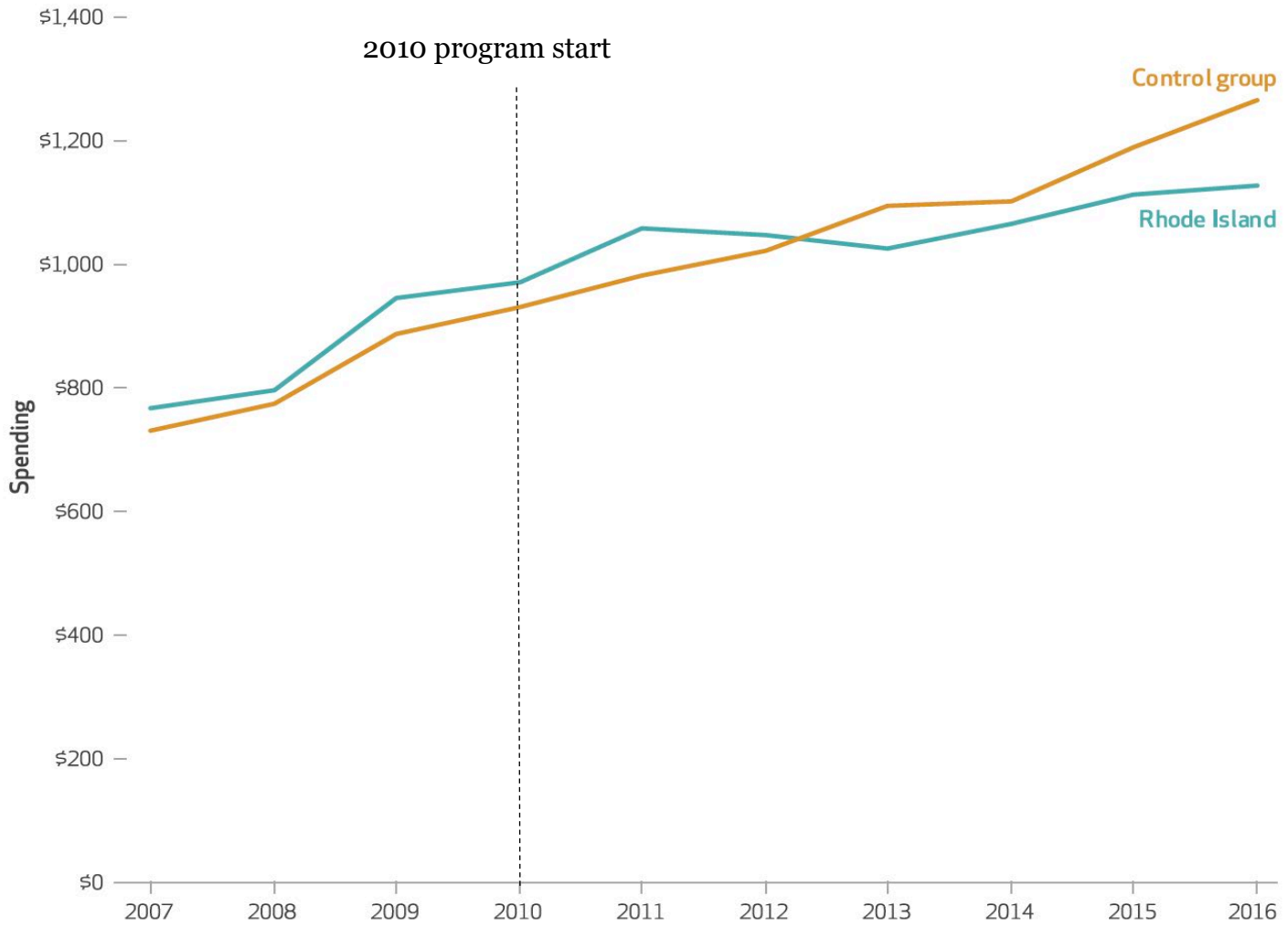
- 200% of Medicare hospital payment cap for Oregon public employees and teachers led to a 25% reduction in outpatient prices per procedure and a 3% reduction in inpatient prices per admission
- $54 million in savings / year
- Similar policy in CA could save $983 million / year

Source: Hospital Facility Prices Declined As A Result Of Oregon's Hospital Payment Cap. Roslyn C. Murray, et al. Health Affairs 2024

Affordability standards reduce spending

EXHIBIT 2

Quarterly per enrollee fee-for-service spending in the Rhode Island and control-group cohorts, 2007–16



- Rhode Island's 2010 affordability standards have slowed spending relative to neighboring states
- 8.1% reduction in spending
- No impact on quality or access to care

Source: Health Care Spending Slowed After Rhode Island Applied Affordability Standards To Commercial Insurers. Aaron Baum, et al. Health Affairs 2019

Conclusion

- Rising health care costs place tremendous pressure on employers and worker wages
- The wide variation in hospital prices presents a potential savings opportunity for patients, employers and purchasers
- Purchasers need to demand and use transparent information on the prices they—and their workers—are paying
- State and federal policies need to ensure employers and purchasers are on equal playing fields and health care markets are competitive

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BROWN UNIVERSITY

Thank you!

Christopher Whaley
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HCAi
Department of Health Care Access and Information

OHCA Statutory Authority to Address High Costs

Vishaal Pegany, Deputy Director

OHCA and the Board's Mission

Purpose of OHCA and this Board. OHCA's enabling statute notes that:

- "...affordability has reached a crisis point as health care costs continue to grow.
- As costs rise, employers are increasingly shifting the cost of premiums and deductibles to employees, negatively impacting the potential for wage growth.
- Escalating health care costs are being driven primarily by high prices and the underlying factors or market conditions that drive prices.
- Californians of color experience health disparities, including barriers to accessing care, receiving lower quality of care, lack of access to culturally and linguistically competent care, and experiencing worse health outcomes.
- Surveys show that people are delaying or going without care due to concerns about cost, or are getting care but struggling to pay the resulting bill."

Defining Sectors and Establishing Sector Targets

Health Care Sectors and Spending Targets

Statutory Requirements for Timing and Process

- **On or before October 1, 2027**, the board shall define initial health care sectors, which may include geographic regions and individual health care entities, as appropriate, except fully integrated delivery systems, considering factors such as delivery system characteristics. Sectors may be further defined over time. The office shall promulgate regulations accordingly.
- **Not later than June 1, 2028**, the board shall establish specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate, in accordance with this chapter.
- Once sectors are defined in regulation, the office and board will follow the statutory requirements for setting sector targets by June 1, 2028, as these requirements pertain to all spending targets established by the board.

Process for Public Meetings

- The board shall hold a public meeting to discuss the development and adoption of recommendations for specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities.
- The board shall deliberate and consider input, including recommendations from the office, the advisory committee, and public comment. Cost targets and other decisions of the board consistent with this section shall not be adopted, enforced, revised, or updated until presented at a subsequent public meeting.

Health Care Sectors and Spending Targets

Statutory Requirements for Timing and Process

- The office shall publish on its internet website its recommendations for proposed cost targets for the board's review and consideration. The board shall discuss recommendations at a public meeting for proposed targets **on or before March 1** of the year prior to the applicable target year.
- The board shall receive and consider public comments for 45 days after the board meeting.
- **Not later than June 1, 2028**, the board shall establish specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate, in accordance with this chapter.

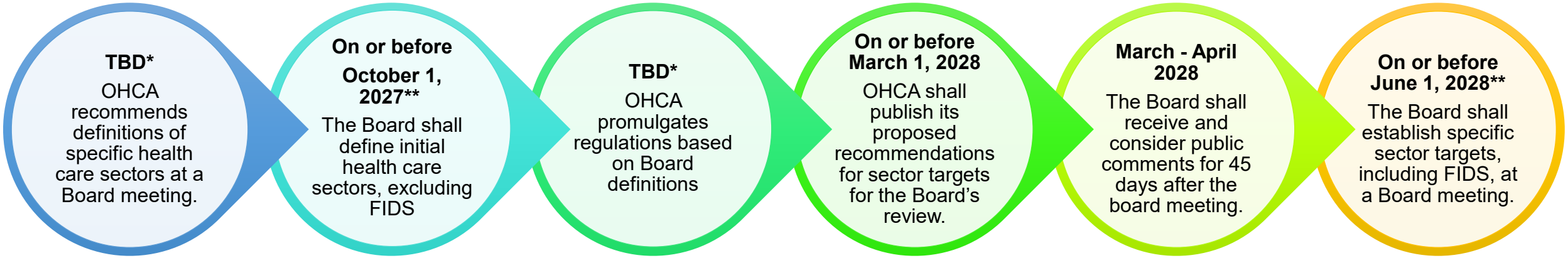
Health Care Sectors and Spending Targets

Statutory Requirements for Setting Sector Targets

- The setting of different targets by health care sector shall be informed by historical cost data and other relevant supplemental data, such as financial data on health care entities submitted to state agencies and the Health Care Payments Data Program, as well as consideration of access, quality, equity, and health care workforce stability and quality jobs.
- Development of sector targets will be done in a manner that minimizes fragmentation and potential cost shifting.
- The board may adjust sector targets as necessary to account for baseline costs in comparison to other health care entities in the health care sector and geographic region.
- It shall also encourage cooperation in meeting the statewide and geographic region targets.
- Sector target definitions will specify the single sector target that is applicable if an entity falls within multiple sectors.

Health and Safety Code § 127500.2 and § 127502

Timeline for Establishing Sector Targets



* To be determined
** For the definition of sectors and for the establishment of sector targets, two Board meetings are required – one for discussion and one for the vote.

HCAI Department of Health Care Access and Information

Defining Sectors and Setting Sector Targets

Options

- Definitions for the Board's consideration may include but are not limited to:
  1. Geographic Regions
  2. Categories of Provider Organizations
  3. Categories of Payer Markets
  4. Individual Health Care Entities
- Fully integrated delivery systems are already defined in the statute and are required to have their own target.
- The statute also requires that the definition of health care sectors consider factors such as delivery system characteristics and allows sectors to be further defined over time.

Geographic Regions

Geographic regions may either be:

1. The regions specified in Section 1385.01 of the California Health and Safety Code,

2. Or may be otherwise defined by the board.

Note: OHCA is collecting spending data to support geographic analysis by Covered California rating regions, except for Los Angeles County. For Los Angeles County, OHCA is collecting data by Service Planning Areas.

Individual Health Care Entities

The OHCA statute defines health care entities as a **payer**, **provider,** or **fully integrated delivery systems (FIDS).** Because FIDS are already defined as a sector, individual health care entity sectors could apply to payer and/or provider entities.

Payers include:

- Health care or specialized mental health plans.
- Licensed health insurers (also includes specialized behavioral health-only policies)
- Publicly funded health care programs, including Medi-Cal and Medicare
- A third-party administrator
- Any other public or private entity, other than an individual, that pays for or arranges for the purchase of health care services on behalf of employees, dependents, or retirees

Providers include:

- Physician organizations comprised of 25 or more physicians
- Hospitals
- Clinics
- Ambulatory surgical centers, or outpatient settings
- Clinical laboratories
- Imaging facilities

Individual Health Care Entities – Methodology

The methodology for setting a sector target for an individual health care entity shall be developed to:

(1) Allow for the setting of cost targets based on the entity's **status as a high-cost outlier**.

(2) Allow for the setting of cost targets that encourage an individual health care entity to serve populations with greater health care risks by incorporating all of the following:

A. A **risk factor adjustment** reflecting the health status of the entity's patient mix.

B. An **equity adjustment** accounting for the social determinants of health and other factors related to health equity for the entity's patient mix.

C. A **geographic cost adjustment** reflecting the relative cost of doing business, including labor costs in the communities the entity operates.

Determining High-Cost Outlier Status

- While OHCA has a definition for high-cost outlier status, that definition is for the purpose of subjecting organizations with less than 25 physicians to the spending target.
  - "…an organization of less than 25 physicians, but that is a high-cost outlier is an entity whose costs for the same services provided in a geographic region are substantially higher compared to the statewide average, as identified through data sources that include, but are not limited to, data from state and federal agencies, other relevant supplemental data, such as financial data on providers that is submitted to state agencies, or data reported to HCAI…. The cost of delivering the same services in a geographic region shall be considered to the extent that cost substantially deviates from the statewide average and reflects higher costs in that region unrelated to the market dominance of providers in that region or unrelated to the ownership, management, or asset structure chosen by the organization."
- To determine an individual health care entity's status as a high-cost outlier, the above definition could be leveraged, or a new approach could be developed.

Health and Safety Code § 127500.2 (p)

Fully Integrated Delivery Systems

- A fully integrated delivery system (FIDS) is a system that includes a physician organization, health facility or health system, and a nonprofit health care service plan that provides health care services to enrollees in a specific geographic region of the state through an affiliate hospital system and an exclusive contract between the nonprofit health care service plan and a single physician organization in each geographic region to provide those medical services.
- Kaiser is currently the only health system in California that meets this definition of a fully integrated delivery system.
- OHCA has instructed submitters to attribute member spending (including hospital spending) to Kaiser's two physician organizations:
    1. The Permanente Medical Group in Northern California
    2. Southern California Permanente Medical Group in Southern California
- OHCA will apply the statewide spending target to each of these systems (northern and southern).

Fully Integrated Delivery Systems - Methodology

Until the board approves sector targets for fully integrated delivery systems, fully integrated delivery systems shall comply with the statewide cost target.

- Targets set for fully integrated delivery systems shall include:
  - All health care services, costs, and lines of business managed by that system in each separately administered geographic service area of the state.
  - Targets on payer administrative costs and profits.
- The system shall provide sufficient data and information, comparable to other unintegrated payers and providers, including patient risk mix, to the office to enable analysis and public reporting of performance, including by sector, insurance market, line of business, and separately administered geographic service area.
- After the board approves sector targets for fully integrated delivery systems, a fully integrated delivery system shall be subject to a target for each of its geographic service areas in which a single medical group is responsible for providing, or arranging for the provision of, all professional services to the payer's enrollees.

Cost and Market Impact Reviews and Market Failures

OHCA Responsibilities Regarding Market Failures

Health & Safety Code 127507(a) Monitor & Conduct Research

The office shall ***monitor cost trends, including conducting research and studies on the health care market,*** including but not limited to, the impact of consolidation, market power, venture capital activity, profit margins, ***and other market failures on competition, access, quality, and equity.***

Health & Safety Code 127501(c)(12) Cost & Market Impact Reviews

The office shall ***review and evaluate*** consolidation, market power, *and* ***other market failures through cost and market impact reviews*** of mergers, acquisitions, or corporate affiliations involving: health care service plans, health insurers, hospitals or hospital systems, physician organizations, pharmacy benefit managers, and other health care entities.

Health & Safety Code 127501.11(c) Present for Board Discussion: Methods of Addressing

The director shall present to the board for discussion – ***methods of addressing consolidation, market power, and other market failures***.

Health & Safety Code 127502.5(g) Data indicates market failure

If data indicate adverse impacts on cost, access, quality, equity, or workforce stability from consolidation, market power, **or other market failures**, the director **may** at any point, **require** that a cost and market impact review be performed on a health care entity, consistent with Section 127507.2.

HCAi
Department of Health Care Access and Information

Public Comment

HCAi
Department of Health Care Access and Information

General Public Comment

Written public comment can be emailed to: ohca@hcai.ca.gov

Next Board Meeting:

September 25, 2024
10:00 a.m.

Location:
2020 West El Camino Avenue
Sacramento, CA 95833

OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

Adjournment

HCAI
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Appendix

58 county map/ Covered CA Rating Region Maps

HCAI
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