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Department of Health Care Access and Information

Health Care Affordability Board Meeting

October 24, 2023

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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 Items**
   Vishaal Pegany
   a) Approval of the September 19, 2023 Meeting Minutes

4. **Informational Items**
   Vishaal Pegany, Deputy Director, and Michael Bailit, Bailit Health
   a) Spending Target Discussion including Historic Trends by Market and Historic and Forecasted Data on Growth Rates of Economic- and Population-Based Indicators

5. **Action Items**
   CJ Howard, Assistant Deputy Director
   a) Establish a Subcommittee to Work with Staff on the Spending Target Methodology and Values for Targets

   b) Elect a Vice-Chair

6. **Public Comment**

7. **Adjournment**

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Executive Updates

Elizabeth Landsberg, Director
Vishaal Pegany, Deputy Director

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 September 19, 2023 Board Meeting Minutes

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Informational Items

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Total Health Care Expenditures (THCE) Measurement

Vishaal Pegany, Deputy Director
CJ Howard, Assistant Deputy Director
Michael Bailit, Bailit Health

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Spending Target Setting Discussion

Vishaal Pegany, Deputy Director
CJ Howard, Assistant Deputy Director
Michael Bailit, Bailit Health

Statutory Concepts For Today's Discussion

The enabling statute requires OHCA to develop a methodology, for approval by the Board, to set spending targets. The spending targets themselves also have certain requirements. Following is a distinction between the two terms:

- **Target Methodology:** The process and review of data to perform the following:
  - Inform spending target setting;
  - Consider potential adjustment factors for future targets;
  - Consider criteria and adjustment factors related to Medi-Cal;
  - Evaluate adjustments related to quality performance; and
  - Effectuate adjustments for organized labor costs.

- **Target Setting:** The actual spending growth target percentage value(s).

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• Be available and transparent to the public. • Based on a review of historical trends and projections (forecasts) of economic and population-based measures. • Based on a review of historical cost trends, with differential treatment for COVID-19 years. • Consider potential factors to adjust future cost targets, including but not limited to health care employment cost index, labor costs, CPI-U, and other factors.	• Be developed with a methodology that is transparent and available to the public. • Promote a predictable and sustainable rate of change in per capita THCE. • Be based on a target percentage, with consideration of economic indicators and/or population-based measures. • Be set for each calendar year, with consideration of multi-year targets. • Be updated periodically and consider relevant adjustment factors. • Promote improved affordability, while maintaining quality and equitable care, including consideration of persons with disabilities and chronic illness.

* These criteria are summarized from Article 3. Health Care Cost Targets [Health and Safety Code section 127502].

Statutory Concepts For Future Discussions

The Methodology	The Target	Sector Targets
• Consider several criteria related to Medi-Cal, including but not limited to the non-federal share of spending, maintaining federal requirements to ensure full federal financial participation and health care related taxes or fees provide the non-federal share. • Allow the board to adjust cost targets downward, when warranted for health care entities that deliver high-cost care that is not commensurate with improvements in quality. • Allow the board to adjust cost targets upward, when warranted, for health care entities that deliver low-cost, high-quality care. • Require the board to adjust cost targets, as appropriate, for a provider or a fully integrated delivery system to account for actual or projected nonsupervisory employee organized labor costs.	• Be developed, applied and enforced. • Promote improved affordability, while maintaining quality and equitable care, including consideration of persons with disabilities and chronic illness. • Promote the stability of the health care workforce. • Be adjusted for provider entities to account for growth in organized labor costs.	• The board can set targets by sector including by geographic regions, types of health care entities and individual health care entities.

* These criteria are summarized from Article 3. Health Care Cost Targets [Health and Safety Code section 127502].

Recap of September Board Discussion on Spending Target Methodology

- Board members expressed a strong preference for consumer-centric indicators (e.g., median family income or wages) to inform the target value.
  - To the extent wages are used, there was interest in using the median instead of mean (or average).
- Board members did not suggest additional economic indicators beyond what was discussed during the September meeting but offered suggested population measures for OHCA's consideration, including housing sector affordability, health care utilization, disability status, and race and ethnicity.
- One member also requested information on 2024 commercial premium increases.

Historical Health Care Spending Growth in California

Statutory Concepts For Today's Discussion

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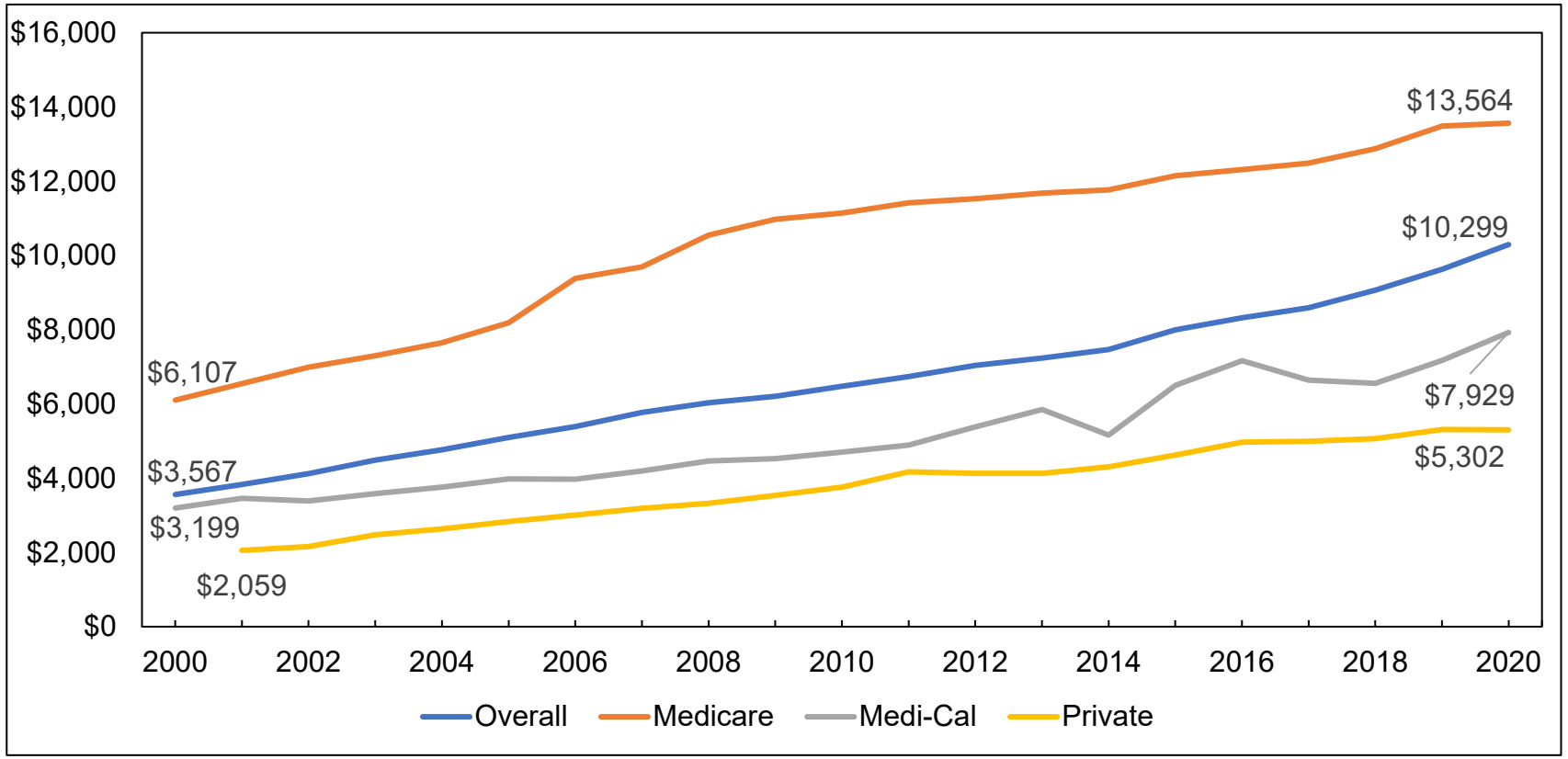
Per Capita Health Care Spending in California, 2000-2020



- From 2000 to 2020, overall per capita health care spending grew 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%

Note: Health care spending refers to personal health care spending, which excludes public health activities, health insurer administrative expenses and profit, government administration, and investment.

Source: State Health Expenditure Accounts by State of Residence, 1991-2020, Centers for Medicare & Medicaid Services. Chart courtesy of the California Health Care Foundation.

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.

Source: State Health Expenditure Accounts by State of Residence, 1991-2020, Centers for Medicare & Medicaid Services. Courtesy of the California Health Care Foundation Health Care Costs Almanac.

Rate Changes in the Individual, Small and Large Group Markets, 2019 to 2024

	Individual Market	Small Group Market	Large Group Market
2020	1.1%	3.4%	4.3%
2021	-0.1%	2.0%	4.2%
2022	2.0%	3.1%	4.1%
2023	6.6%	5.9%	Not available
2024	10.4%	8.4%	Not available

Source: Department of Managed Health Care (DMHC).
Notes: Rate changes are enrollment-weighted. Individual market rate changes differ from Covered California's since DMHC rate filings include off-exchange products.

Staff Recommendation Related to Historical Cost Trends

- To promote improved affordability, the annual per capita health care spending growth target percentage should be below the long-term trend of 5%.
- There are anomalies associated with the impact of COVID on health care spending. As such, this recommendation does not consider calendar years 2020 and 2021. When state-level per capita spending for 2021 and beyond are fully realized, the Office and Board may revisit any impacts on spending associated with COVID-19.

Does the Board have any questions, input, or further guidance on the development of a spending target methodology or target setting based on the review of historical cost trends?

Economic Indicators and Use of Historical vs. Forecasted Growth to Derive Spending Target Value(s)

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Economic Indicators: Historical and Forecasted Experience

There are differences in economic indicators calculated using actual historical data vs. forecasts.

Historical Data

- Historical data reflects, to varying degrees, the volatility of year-over-year changes, including booms and busts, and pandemic times and healthier times.
- Historical figures are relatively easy mathematical calculations (straight average growth over prior time periods).
- Unexpected events can be addressed through smoothing or by extending the time-period.

Forecasted Data

- Forecasted data are designed to be predictable, stable figures and are calculated by government agencies and private firms.
- The California Department of Finance regularly forecasts economic indicators for use in budget setting and for other purposes.
- Methods of forecasting vary by the organization performing the forecast and are affected by the philosophy and outlook of economists at each organization.

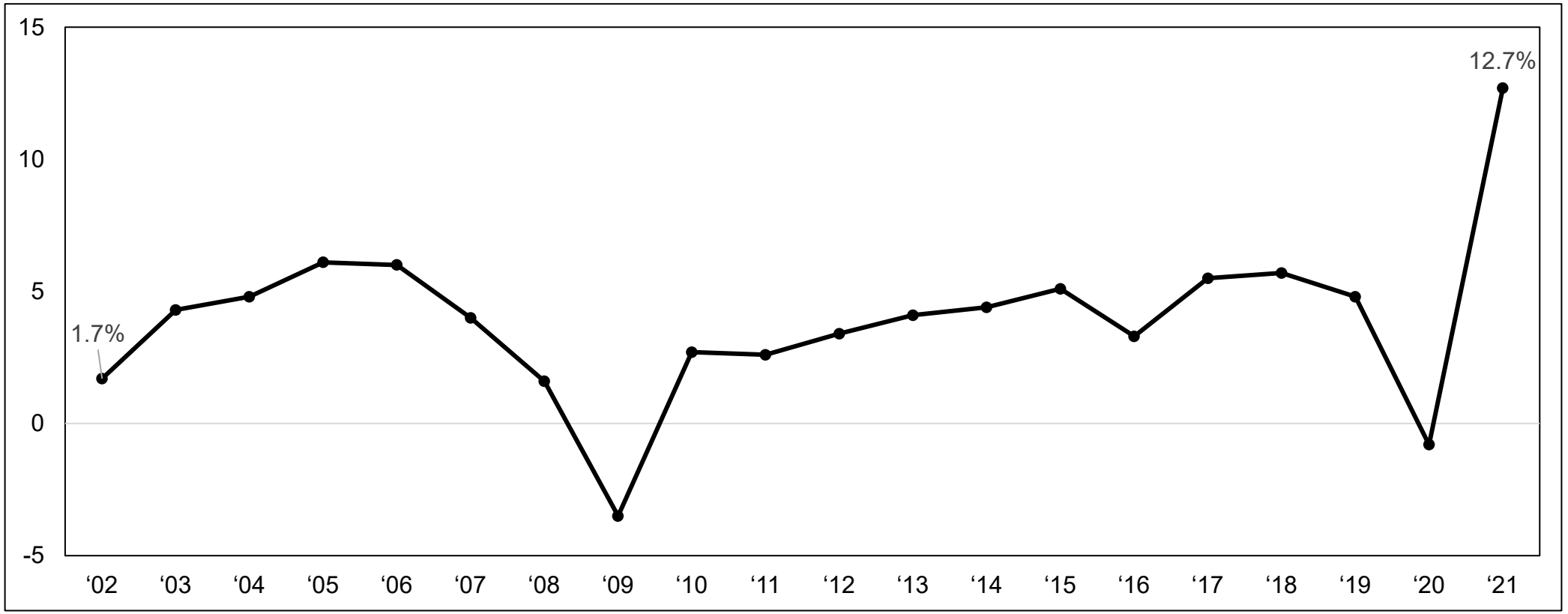
Economic Indicators

Indicator	Historical	Forecast
Gross State Product	**3.9%** *(2002-2021)*	*N/A*
Potential Gross State Product (PGSP)	*N/A*	**4.0%** *(2029-2033)*
Median Wage	**2.8%** *(2002-2021)*	**2.6%** *(2026)*
Median Family Income	**2.8%** *(2002-2021)*	**3.6%** *(2026)*

Source: UC Berkeley Labor Center. What Can We Afford? Aligning Office of Health Care Affordability spending target with Californians' ability to afford increases. September 2023. https://laborcenter.berkeley.edu/wp-content/uploads/2023/09/What-can-we-afford.pdf

Annual Growth Rate In Gross State Product

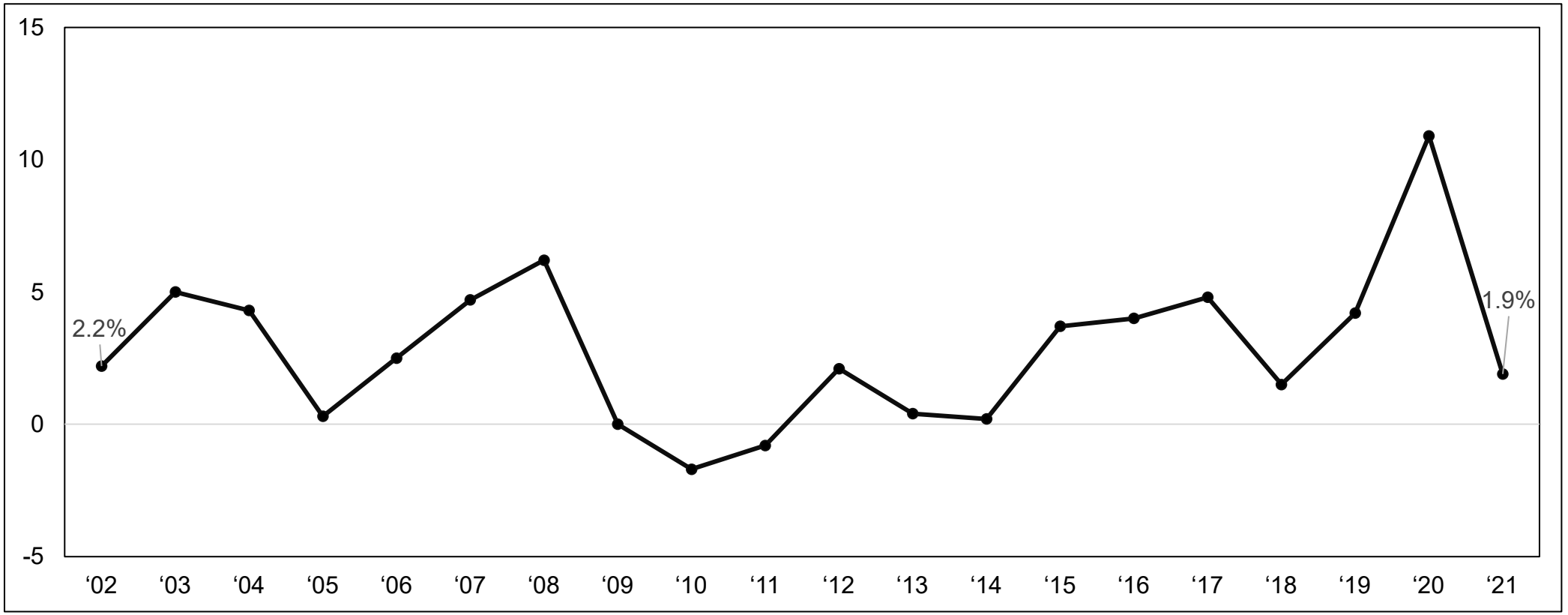
From 2002 to 2021, overall gross state product per capita grew by approximately 3.9% annually.



Source: UC Berkeley Labor Center analysis of data from U.S. Bureau of Economic Analysis, Economic Policy Institute analysis of U.S. Census Bureau Current Population Survey, California Department of Finance.

Annual Growth Rate In Median Wages

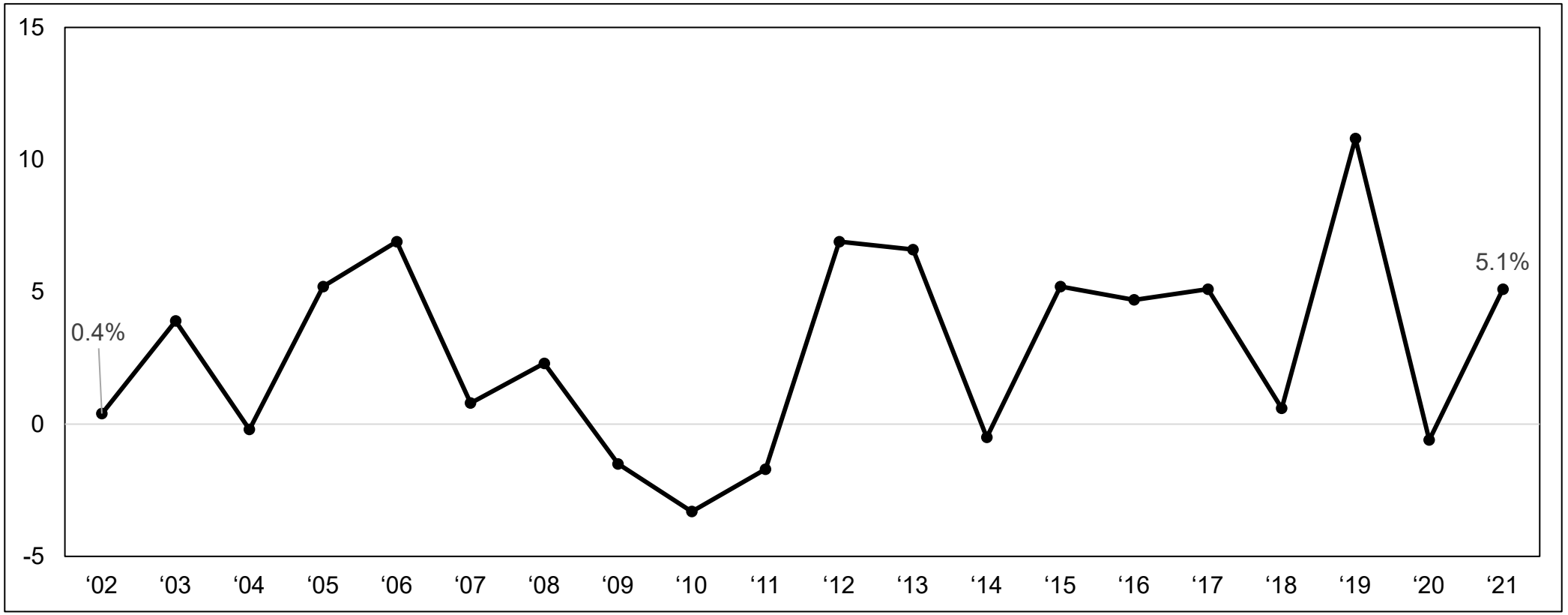
From 2002 to 2021, overall median wages grew by approximately 2.8% annually.



Source: UC Berkeley Labor Center analysis of data from U.S. Bureau of Economic Analysis, Economic Policy Institute analysis of U.S. Census Bureau Current Population Survey, California Department of Finance.

Annual Growth Rate In Median Income

From 2002 to 2021, overall median income grew by approximately 2.8% annually.



Source: UC Berkeley Labor Center analysis of data from U.S. Bureau of Economic Analysis, Economic Policy Institute analysis of U.S. Census Bureau Current Population Survey, California Department of Finance.

Staff Recommendation Related to Economic Indicators

- To promote transparency and public accessibility, the basis for establishing a statewide spending target should be a single economic indicator.
- The methodology to establish a statewide spending target should rely heavily on a single indicator of consumer affordability, specifically, median family income because it captures retirees and others not in the labor market.
  - In several states that have used blended approaches, the average change in median household income over the past 20 years closely aligns with their selected spending target.
- The methodology should rely on historical data over projections.

Does the Board have any questions, input, or further guidance on the development of a spending target methodology or target setting related to economic indicators?

Population-Based Measures to Inform Spending Target Values

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* These criteria are summarized from Article 3. Health Care Cost Targets [Health and Safety Code section 127502].

Should the Target be Adjusted for Projected Changes in Population-Based Measures?

Last month Board members suggested OHCA research the following population-based measures to adjust the spending target value(s):

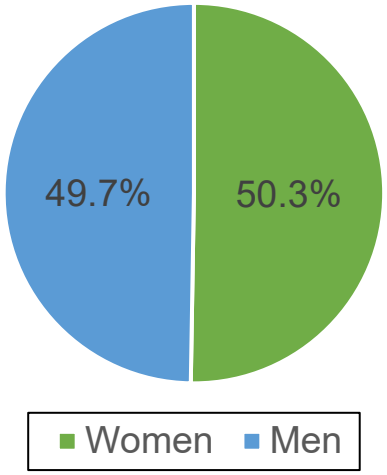
- Age and sex
- Chronic disease prevalence
- Disability status
- *Health care utilization*
- *Affordability measures related to other sectors*

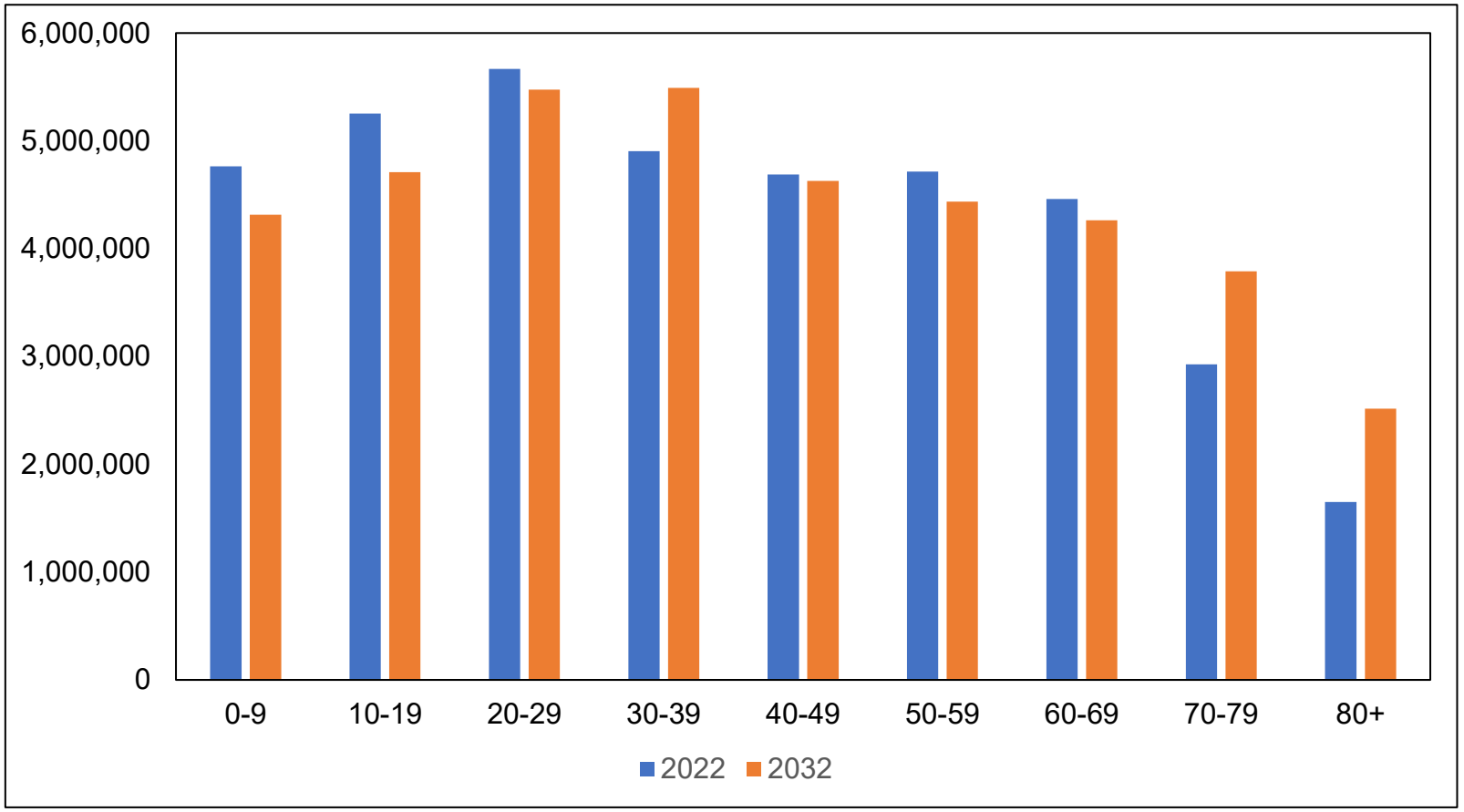
OHCA did not research health care utilization, because it would be a self-referencing adjustment. We are still researching affordability measures related to other sectors as options for population-based measures.

OHCA found adjustments based on population-based measures would be very small and are correlated with one another and potentially other economic indicators.

Forecasted California Age/Sex Trends for 2022-2032

- California is expected to age over the next 10 years, with the largest relative increase in the 70+ population.
- The sex distribution in CA is expected to stay almost identical





Source: Demographic Research Unit, 2020-2060, California Department of Finance, accessed September 2023.

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Models to Forecast Changes in Health Care Spending Due to Age/Sex Trends

- Using population projections provided by the Department of Finance and both Medical Expenditure Panel Survey (MEPS) data and Connecticut's (CT) spending target age/sex risk scores, OHCA generated two sets of projections to model changes in risk due to age/sex factors.
  - MEPS data were collected by the Agency for Health Research and Quality (AHRQ).
    - Utilized a subset of risk scores provided by MEPS created from data from 2002 to 2009
    - Generated using nationwide surveys – data included over 100,000 participants
  - CT's age/sex risk scores were generated using demographic and spending data reported by payers to the state.
    - Utilized a subset of the population: Medicare Advantage, Commercial Full Claims, and Medicaid (non-duals)

Potential Adjustments to Spending Targets Due to Changes in Forecasted Age/Sex

The table below displays the expected change in spending due to age/sex factors alone for 2022-2032 using MEPS and CT age/sex risk scores.

Market	10-Year Change in Risk due to MEPS Age/Sex Factors	10-Year Change in Risk due to CT Age/Sex Factors	Potential Annual Target Adjustments
Commercial	0.3%	0.2%	0.02% - 0.05%
Medicare	3.9%	2.6%	0.30% - 0.40%
Medi-Cal	1.3%	0.3%	0.05% - 0.15%
Cross-Payer	1.6%	0.9%	0.10% - 0.15%

Disability Status Adjustment

The American Community Survey, administered by the US Census Bureau, estimates disability prevalence nationwide and by state.

- The survey is sent to a sample of 3.5 million people every year, nationwide.
- The response rate was greater than 80% in all years between 2010-2021, except for 2020.
- The survey estimates that about 11.2% of Californians had a disability as of 2021.
- The primary limitation of the survey – for our purposes - is that it relies upon self-report rather than an objective functional measure of disability status.

Disability Status Adjustment

Two separate studies, using MEPS data, found that spending for individuals with disabilities was several times more than those without disabilities:

- One study utilized data from all persons 18-64 in the 2014 MEPS panel (N = 20,898) to compare the spending among those with disabilities to those without a disability and found a spending ratio of **$13,492 to $2,835 (or 4.8 to 1)**.
- A second study used 2013-2015 MEPS data (N = ~100,000) data to produce a counterfactual analysis (i.e., assuming adults with disabilities had no disabilities, but all else was held constant, what would their spending have been). This study found a spending ratio of **$24,114 to $6,683 (or 3.6 to 1)** for a person with disability compared to the same person's spending had they not had a disability.
- Limitations: Prevalence correlated with aging. Also, the studies did not generate a spending differential by market.

Sources: (1) Kennedy et al. 2017. Disparities in Insurance Coverage, Health Services Use, and Access Following Implementation of the Affordable Care Act: A Comparison of Disabled and Nondisabled Working-Age Adults. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5798675/; (2) Khavjou et al. National Health Care Expenditures Associated With Disability. Med Care. 2020 Sep;58(9):826-832. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7505687/

Disability Status Adjustment

In California, from 2010-2021, disability prevalence increased about 0.1% on a year-over-year basis.

- People with disabilities tend to have 4-5 times higher spending than people without disabilities.
- Prevalence varies by insurance market.

Market	Potential Annual Disability Adjustment
Commercial	0.2% - 0.3%
Medicare	0.1% - 0.2%
Medi-Cal	0.1% - 0.2%

Chronic Illness Adjustment

The California Department of Public Health and UC Davis jointly studied the change in spending from 2010 to 2016 for patients with chronic conditions.

- Spending on chronic illness was estimated using the CDC cost calculator (based on MEPS data) and total spending using CMS average annual per person medical expenditure.
- Prevalence and spending was assessed from six chronic illnesses: arthritic, asthma, cancer, cardiovascular disease, diabetes, and depression.
  - Sources: California Health Interview Survey, the Surveillance Epidemiology and End Results (SEER) data, and the American Diabetes Association
- Limitations: Chronic illness prevalence correlated with aging and with disability status. Also, data not disaggregated by market.

Source: UC Davis and California Department of Health, 2016 Estimated Health Care Expenditures of Chronic Disease in California

Chronic Illness Adjustment

For the six conditions, there was an observed (weighted) average increase of about 1.6%, while spending on chronic illness as a proportion of total spending increased about 2.1% over the six-year period.

- This is likely captured, to a significant extent, by increases in the rates of disability and by changes in age/sex factors.

Potential Annual Chronic Illness Adjustment
0.3% - 0.4%

Staff Recommendation Related to Population-Based Measures

OHCA advises further analysis on the use of population-based metrics to adjust the statewide spending target.

- OHCA notes that no other state has incorporated population-based measures and adjustments based on population-based measures would be minimal.

Does the Board have any questions, input, or further guidance on adjusting targets for forecasted changes in the age/sex of the population, disability status, or chronic illness?

Multi- or Single-Year Target Setting

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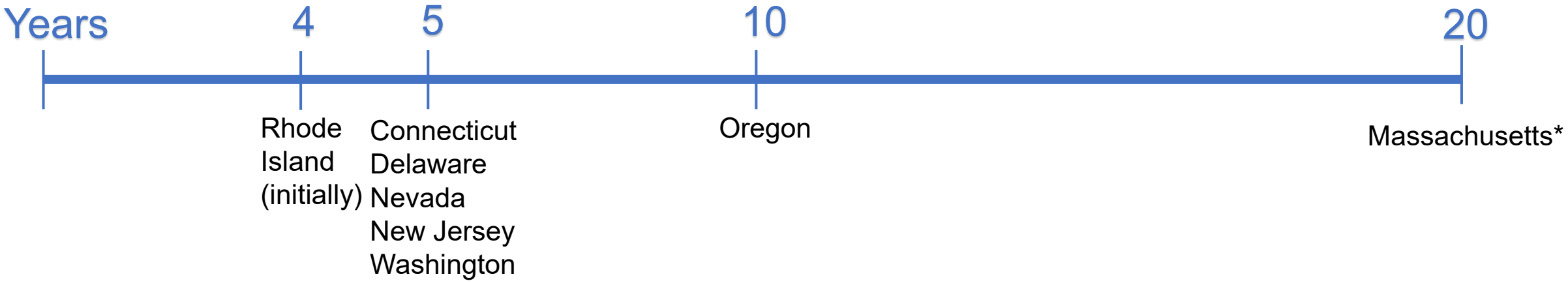
Other States' Approaches to Target Duration

- Other states have set target values that span multiple years, so plans and providers know what the target value will be well ahead of time.
- The length of time for which states have set spending targets ranges from 4-20 years.



* Established in statute.

One Year or Multi-Year Target: Pros and Cons

	Pros	Cons
One Year	• Can adjust the target value for changing environmental circumstances (allowing for adjustments relative to the target is another way).	• Time consuming and does not provide plans and providers with as much notice to respond to the target. • Target setting is best informed by prior years' target performance, but reporting is delayed two years after the performance year.
Multiple Years	• Knowing future targets in advance could influence negotiations for health plan contracting. • Promotes *predictable and sustainable* rates of change.	• Cannot anticipate the impact of significant future events (e.g., COVID-19's impact in service utilization in 2020 and 2021) that may change the pattern of health care spending.

If Setting Multi-Year Targets… For How Many Years?

	Pros	Cons
2-3 years	• Aligns with health plan contracting cycles that are typically 2-3 years.	• Public results of Year 1 data will not be available until Year 3, so 2-3 years may not be long enough.
4-5+ years	• Making the required changes in health plan and provider operations takes time. Having a 4+ year target can assist strategic planning.	• Would not account for unknown events that may significantly influence health care spending and utilization (e.g., pandemics, significant macroeconomic changes), but can be mitigated through establishing criteria for revisiting the target.

Fixed or Phased-in Multi-Year Target?

Fixed Target: One target value set for a predetermined number of years.

Phased-In: The target value progressively decreases in the first several years of implementation to reach an ideal target (E.g., Connecticut set a value of 2.9%, but added 0.5% for the first year of implementation and 0.3% for the second year.)

	Pros	Cons
Fixed	• Creates a steady, easy-to-remember, expectation.	• Does not facilitate a slow transition for providers and payers – if one is believed to be needed to be successful.
Phased-In	• Allows for an “ease-in” period for health plans and providers.	• Small incremental changes may not be meaningful compared to one larger change.

Staff Recommendation Related to Target Setting Duration

- Initial targets should be set for five calendar years: 2025, 2026, 2027, 2028, and 2029 to provide for sufficient planning.
- After the first annual report on calendar year 2026 is released in 2027, the board will have an opportunity to review the effectiveness of the target values and compliance by health care entities.
- The target value should be phased-in (i.e., progressively decrease) over the first 2-5 years of the program, then remain fixed.

Does the Board have any questions, input, or further guidance related to target setting duration?

Adjusting the Spending Target

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Other States' Criteria For Changing the Target Methodology and/or Target

- **Connecticut** may revisit the methodology and calculation should there be a sharp rise in inflation between 2021 and 2025.
- **Delaware**'s State's Finance Committee annually reviews the target methodology and can change the target if the PGSP forecast changes in a "material way."
- **Massachusetts** set the target in statute but there is a process for the Health Policy Commission to modify the value, subject to legislative review.
- **Oregon** and **Washington** do not have official adjustment triggers, but both states revisited their methodologies as a result of the inflation experienced in 2021 and 2022.
- In **Rhode Island**, "highly significant" changes in the economy can trigger re-visiting of the target methodology.

Are There Conditions That Warrant Revisiting the Target Mid-year or Mid-cycle?

Yes	No
Allowing for adjustments in the target because of external events that impact health care spending can ensure that plans and providers are not held accountable for growth that is beyond their control (e.g., future pandemics).	While certain events can trigger a significant increase in health care spending, allowing the target to be adjusted as a result means: a) the consumer will bear the burden of increased costs; and b) plans and providers cannot plan and manage to the target.

Adjusting the Spending Target

Does the Board have any questions, input, or further guidance related to target setting adjustments?

Are there conditions that would warrant the Board to reconsider the selected target value(s)?

Next Steps

- Further refinement of target setting methodology
- Discussion of target setting and target values
- Discuss target setting methodology and target values with Advisory Committee

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Public Comment

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Action Items

Establish Spending Target Subcommittee

Does the Board wish to establish a subcommittee to work with staff on the spending target methodology and the values for targets?

Election of a Board Vice-Chair

Does the Board wish to elect a Health Care Affordability Board Vice-Chair?

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General Public Comment

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

Next Board Meeting:

December 19, 2023
10:30 a.m.

Location:
2020 West El Camino Avenue
Sacramento, CA 95833

Next Advisory Committee Meeting:

November 30, 2023
10:00 a.m.

Board Attendees: Sandra Hernández and Richard Kronick

Location:
2020 West El Camino Avenue
Sacramento, CA 95833

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Adjournment