California Association of Health Plans

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Sent via email:
ohca@hcai.ca.gov

Mark Ghaly, M.D.
Chair, Office of Health Care Affordability
1215 O Street
Sacramento, CA 95814

Re: Total Health Care Expenditures Rulemaking

Dear Secretary Ghaly and OHCA Board Members:

The California Association of Health Plans (CAHP) represents 43 public and private health care service plans (plans) that collectively provide coverage to over 28 million Californians.

Over the last several months, the Office of Health Care Affordability (OHCA) has engaged its staff, its leadership, and industry stakeholders in robust discussions surrounding the collection and measurement of Total health Care Expenditures (THCE) data. Our member plans are grateful to be involved in these discussions, and we look forward to our continued partnership with OHCA in addressing rising health care costs.

Measuring health care costs is the foundational building block for the rest of the work that OHCA will engage in. It is very complicated and should not be rushed.

While we understand that OHCA's goal is to move quickly and fill out the details later through sub-regulatory guidance or updates to the rulemaking, we believe that would be a mistake. Critical issues have not been resolved. It is not reasonable to ask the public to comment on setting spending targets when the details around measuring health care costs are still developing. These key issues have not been resolved in a satisfactory manner:

Measuring Health Care Costs at the Provider Level is Not Working

Payers and fully integrated delivery systems are required to submit THCE data by the statutory deadline of September 1, 2024, and a critical piece of the THCE data submission process involves the Addendum to the THCE Data Submission Guide, which payers will use to attribute total medical expenses (TME) to certain physician organizations. Payers have regularly been collaborating with OHCA staff to identify lists of provider entities and determine the most effective reporting methods, but these conversations are ongoing and there are still many outsanding issues that must be resolved.

Payers have tried to fill in various data submission templates for OHCA, but many of those templates don't work, and the payers continue to go back and forth with OHCA requesting adjustments. Even if OHCA is considering not reporting spending attributed to physician organizations in the Baseline Report, the data

collection process still needs to be better defined before the THCE Data Submission Guide and Addendum are finalized.

OHCA's enacting statute envisions accountability for all health care organizations. While the industry continues to work towards this goal, we believe it is counterproductive to release spending reports on only one part of the health care system and it would present an incomplete picture.

The Measurement Approach Doesn't Work for a Part of the Marketplace

To reiterate some of CAHP's primary concerns from our THCE regulation comments submitted on December 1, 2023, the regulation, Data Submission Guide, and Attribution Addendum approach will generally work for HMO members and providers, but the approach will not work for non-HMO/ broader network members and providers (e.g., PPO, EPO products). There is no easy solution.

To obtain reliable data, OHCA will need to work with providers and payers to drive fundamental changes in how providers are contracted. Providers and OHCA will need to develop a registry of Physician Organizations that are uniquely identified and then cascade this registry throughout the delivery system in terms of payer/provider contracting, significant system updates, etc.

Further, membership and health care spend attribution to provider entities in a PPO/fee-for-service environment does not work. The cost benchmarking data collection assumes a false construct in two main ways: (1) As currently structured, there are a significant number of situations where members and their costs for the year will be assigned to the wrong provider entity via the cost benchmarking data collection construct. Fee-for-service claims adjudication is set up to pay for services. These claims adjudication systems, contracts, etc. are not set up in a way to drive accurate reporting to provider entities as OHCA is defining those entities; and (2) It assumes a false premise in the existing health care system that a PCP is driving a member's care in a broad network environment. That is sometimes the case, but often is not. Statistically, up to one quarter of members receiving care under a fee-for-service system will never be attributed. OHCA should examine how the THCE regulations, Data Submission Guide, and Addendum could include a first-order differentiation in data collection and reporting to distinguish between PPO and HMO product lines.

There is more work to be done. We are concerned that rushing the process will lead to an innacurate measure of health care spend in California and we hope to engage OHCA's leadership in further discussion to prevent such innacuracies from clouding the big picture.

Measuring Hospital Pricing and Other Significant Cost Drivers is Unresolved

Hospital costs drive health care care costs, and specialist groups should be included in that discussion as well. The fact that there is still no clarity on how they will be measured—while a 45-day clocking is ticking to adopt regulations and a spending target—is highly concerning. This issue is too important to be kicked down the road.

OHCA Board members have also pointed out that pharmaceutical pricing is one of the key drivers of medical spend. The Department of Managed Health Care (DMHC) recently released the Measurement Year

2022 SB 17 Prescription Drug Transparency Report, which states that since 2017, prescription drug costs paid by health plans increased by $3.4 billion or 39%.

A key component of OHCA's mission, as stated on its website homepage, is to "increase public transparency on total health care spending in the state," which includes, "collect[ing] total health care expenditure data, broken down by service category (e.g., hospital care, physician services, prescription drugs, etc.)." Instead of passing a threadbare regulation and filling in gaps later with updates and revisions, we should focus on defining and refining the process as much as possible at the front end, so that OHCA can collect complete, accurate, usable THCE data from the full spectrum of submitters. If transparency is OHCA's goal, hospital costs and pharmaceutical pricing are key factors driving up the cost of health care in California, and they need to be accounted for in the THCE and spending target methodologies.

Without Additional Clarity Surrounding THCE Data Collection Processes, Adopting a 3.0% Spending Target is Premature

From a process perspective, all the existing 'buckets' of OHCA activity—the CMIR regulations, the THCE regulations, the proposed spending target methodology—are bunching together and overlapping so rapidly that transparency and clarity are falling by the wayside.

During the spending target presentation at the December 2023 OHCA Board Meeting, OHCA staff explained that the proposed 3.0% target value was arbitrary in nature. We agree. We also believe that this issue is too important to be set arbitrarily. The spending target should be thoughtfully developed, using more robust and varied data sources, and with clarity for the public on how the base measurement will be developed, and how health care costs will be measured over time. A realistic target should also account for inflationary pressures, health care workforce shortages, wage pressures driven by recent legislation, and other critical factors. The 45-day clock has already started running for stakeholders to comment on OHCA's proposed spending target methodology, but it is challenging to comment on the target value when we consider how much information is still missing from the conversation.

In Conclusion, OHCA Should Delay the THCE Regulations

CAHP recommends that OHCA refrain from finalizing the THCE regulations until the above issues are resolved. We share OHCA's long-term vision of creating a workable system that will manage health care cost growth and improve affordability, but that calls for thoughtful, in-depth analysis and discussion of underlying methodologies so we can get things right the first time.

CAHP appreciates OHCA's consideration of our members' comments and concerns.

Sincerely,

Charles Bacchi
President and CEO

Cc: Members of the Health Care Affordability Board