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

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HEALTH CARE AFFORDABILITY BOARD

MEETING MINUTES
Tuesday, July 22, 2025
10:00 am

Members Attending: Dr. Sandra Hernández, Secretary Kim Johnson, Richard Kronick, Ian Lewis, Dr. Richard Pan, Elizabeth Mitchell, Don Moulds

Members Absent: None

Presenters: Elizabeth Landsberg, Director, HCAI; Vishaal Pegany, Deputy Director, HCAI; Megan Brubaker, Engagement and Governance Group Manager, HCAI; Margareta Brandt, Assistant Deputy Director, HCAI; Debbie Lindes, Health Care Delivery System Group Manager, HCAI; CJ Howard, Assistant Deputy Director, HCAI

Meeting Materials: **https://hcai.ca.gov/public-meetings/july-health-care-affordability-board-meeting-3/**

Agenda Item # 1: Welcome and Call to Order
Elizabeth Landsberg, Director, HCAI

Director Landsberg opened the July meeting of California's Health Care Affordability Board. Roll call was taken, and a quorum was established.

Director Landsberg provided an overview of the meeting agenda and noted that item 4, Vote to Appoint Advisory Committee Members, will be taken out of order once Chair Johnson arrives. She also explained that OHCA will not be going into detail on the provisions of H.R.1, the federal reconciliation bill, but acknowledged the widespread and destructive impacts of the new law. The California Health and Human Services Agency released a webinar describing the provisions in detail and the impacts in California with presentations by Secretary Johnson and the directors of the Department of Health Care Services, Covered California, and the Department of Social Services.

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

Director Landsberg provided Executive Updates, including the following:

- An acknowledgement of the 35th anniversary of the Americans with Disabilities Act.
- A reminder that the recently enacted budget health trailer bill includes a new requirement for pharmacy benefit managers (PBMs) to report data to the Healthcare Payments Database (HPD), in addition to requiring them to be licensed by the Department of Managed Health Care (DMHC). The data will include information about discounts, rebates, fees, and other payments, including payments made to PBM-owned pharmacies.
    - HCAI has published a fact sheet on the HPD program page that describes the implementation timeline. HCAI will be engaging with PBMs and will seat a PBM representative on the HPD Advisory Committee.
- An announcement that beginning August 1st, the Office of the Patient Advocate (OPA) and the Data Exchange Framework will transition from the California Health and Human Services Agency to HCAI. These two programs align well with HCAI's mission and the work of OHCA.
- An update that HCAI's Workforce Development program launched two new programs under the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (or BH-CONNECT) program: 1) the Medi-Cal Behavioral Health Student Loan Repayment Program; and 2) the Medi-Cal BH Residency Training Program.

Deputy Director Pegany provided the following Executive Updates:

- A review of two recent articles, including: A Health Affairs article highlighting key findings from the 2025 Centers for Medicare & Medicaid Services report on the National Health Expenditures (NHE) projections for 2024.
- A JAMA Health Forum article highlighting key findings regarding California's Commercial-to-Medicare price ratio for hospital services from 2020 to 2023 relative to those for the United States.

- An announcement of OHCA's June 6th determination to conduct its first Cost and Market Impact Review (CMIR), looking at portions of a material change notice submitted by Covenant Care California regarding the transfer of skilled nursing facilities and assisted living facilities. OHCA will publish its preliminary CMIR report on the HCAI website and allow 10 business days for parties and the public to submit written comments in response to OHCA's findings.
    - A reminder about slide formatting.

Discussion and comments from the Board included:

- A member asked when CMS might revise their NHE projections in light of the significant change in federal policy.
    - The Office replied that they typically revise their projections on an annual cadence. If CMS publishes revised projections before then, OHCA will report it to the Board.
- A member referenced the JAMA study and asked which factors are driving the higher-than-average rates in California compared to the United States.
    - The Office stated that the JAMA study did have coefficients for the various factors listed, including hospital concentration, although they are unsure whether these coefficients were on a state level.

- A member questioned whether California has more hospital concentration compared to other states and if that is driving prices.
    - The Office responded that it is likely hospital concentration, based on other research and literature on California's higher hospital concentration in Northern California. This is something OHCA will monitor.
- A member noted that California has a reputation for having lower health care costs than other states, specifically compared to Massachusetts.
    - The Office stated that, while that may be true regarding costs, the referenced study reported on prices for hospital services.
    - A member mentioned that in the study most of the variation across market areas was unexplained.
- A member stated that 2026 rate renewals are beginning to come in and are in line with some of the stated projections and possibly ahead of some of the projections for California. The member expressed concern that it appears the entities will overshoot the spending targets in 2026. The member asked if there has been any discussion with CalPERS, as they just published their latest rate increases and are likely the most sophisticated large group purchaser in terms of connecting targets with rates.
    - A member confirmed that CalPERS just adopted their rates for 2026, which are coming in at approximately 8.2% increase, with higher rates on the PPO and Medicare sides. The HMO rates are coming in a little over 6.5%. Those rates are better than they have been in the previous two years but are largely a reflection of health care spending (a combination of prices and utilization, as well as other factors).
- A member shared that at an annual Kaiser rate increase presentation to their members, their rates are likely double the target which points to clear gaps between the targets and what is happening.
- A member emphasized the importance of the JAMA article, quoting that the findings provide evidence against the presumption that high commercial prices were primarily used to offset losses from public payers and instead contributed to higher profits for the hospital. It is important to understand where some of that money is going.
- A member asked how administrative costs from health plans and pharmacy benefit managers are being evaluated as a driver of price and how will OHCA get at administrative costs.
    - The Office replied that they collect administrative costs and profits for health plans. This is publicly filed and included in Total Health Care Expenditures (THCE). For providers, however, OHCA cannot get to this level of detail as it is baked into the rates they charge and their reimbursements. Since OHCA relies on payer payments to providers, they are unable to get to that level of specificity. Additionally, hospitals report their financial statements so OHCA can see their administrative costs and profits. Physician organizations do not currently file except for risk-bearing organizations with the Department of Managed Health Care. OHCA has statutory authority to collect financial statements from non-risk bearing organizations (RBO) physician

organizations so this is something that OHCA may have greater insight to in the future.
    - A member stated that this is a significant opportunity to address costs without harming access. If there is a source for this administrative entity information it would be helpful.
- A member expressed a concern that when medical loss ratio caps were placed on plans there was an effort to push administrative costs into practices where they go unseen and instead get baked into the bill (e.g. preauthorization and other burdens that are additional costs while denying care).
- A member stated that the major changes at the federal level are deeply concerning and will likely affect health care in California on many levels, starting with the profound losses in coverage as well as the numerous ripple effects especially to the commercial market. The member noted that to the extent OHCA can capture the impacts, it is critical information that can help further conversations with members of Congress. The member also noted the tremendous progress made over the last decade and a half in health care nationally and especially in California and emphasized the importance of pushing back to try to restore some of those gains.
- A member acknowledged the 35th anniversary of the Americans with Disabilities Act as well as excitement for the transition of the Data Exchange Framework to HCAI. and stated that there are still opportunities in the state to achieve administrative savings through implementation of the framework.
- A member reiterated an earlier point that it is important for OHCA to capture the baseline of where the data stands today to begin to understand the ripple effects that H.R. 1 will have in California.

Public comment was held on agenda item 2. Two members of the public provided comments.

Agenda Item# 5a: Update on Behavioral Health Spending Definition and Measurement Methodology (out-of-order)
Margareta Brandt, Assistant Deputy Director; Debbie Lindes, Health Care Delivery System Group Manager

Assistant Deputy Director Brandt and Health Care Delivery System Group Manager Debbie Lindes provided an update on the behavioral health spending definition and measurement methodology workstream progress, including measuring behavioral health claims and non-claims spending, and a timeline for finalizing the definition and measurement methodology so that data submitters can start to utilize it beginning next year.

Discussion and comments from the Board included:
- A member expressed concern that the behavioral health in primary care module might become a deterrent to incentivizing behavioral health integration in primary care, if the measurement captures only claims with a primary behavioral health diagnosis. The member expressed concern that the behavioral health in primary

care module seems to emphasize behavioral health providers over primary care providers who provide behavioral health care, and expressed concern that this might encourage the ongoing fragmentation and incentivize carve-outs. The member asked if there is a way to reconsider just the primary care portion of measurement to better reflect what primary care practices are trying to do. The member noted that plans may not pay for behavioral health services within primary care, even though a service was provided, and that spend may not be captured.
    - The Office replied that the behavioral health in primary care module aims to capture integrated behavioral health care and care provided by primary care providers. Requiring a primary behavioral health diagnosis is part of OHCA's definition of behavioral health spending, and the Office recognizes the complexities of this approach, such as the potential for overcounting or undercounting of behavioral health spending, and has received input from the Investment and Payment Workgroup on the module. The Office added that integrated behavioral health codes are included in the module, and hopes this will encourage primary care providers to use and plans to pay for these codes more.
- Referring to the process map for identifying behavioral health claims, a member asked whether well-child visits would be included in spending measurement when they include a mental health or substance use screening or assessment.
    - The Office confirmed that claim lines with screening and assessment codes are included in the measurement if the providers code for it. Any payments for these screening and assessment procedures that are separate from the main visit (evaluation and management) code are included in the measurement, regardless of any resulting behavioral health diagnosis.
- A member noted that the codes included in the benchmark will influence codes that plans allow or incentivize versus the codes they disincentivize or don't reimburse, which will drive coding behavior by providers. The member added that if the right codes are not captured, we may incentivize behavior that pulls behavioral health out of primary care, which may prove to be more expensive. The member commented that part of the benchmark work might be to measure what plans are doing that encourages their contracted primary care doctors to use codes that allow capture of behavioral health services in measurement. The benchmark will encourage plan behavior and could lead to provider behavior that does not increase access to care at the primary care level or improve affordability.
- A member speculated that there will be less federal focus on non-quantitative treatment limitation enforcement and other mental health parity requirements, and therefore the enforcement responsibility is expected to shift to the Department of Managed Health Care and the Department of Insurance. The member would appreciate seeing synergy between OHCA's measurement efforts and the data those departments may need to enforce the parity laws.
- A member commented that it would be helpful to have a public discussion of the pros and cons of including or excluding drug spend in the benchmark.
- A member expressed concern that apportioning capitation payments based on a standardized fee-for-service equivalent might not reflect actual compensation to behavioral health providers, whose compensation may be at or below Medicare

rates, could incentivize plans to make capitated payments that do not actually go toward behavioral health. The member asked what OHCA can do, including considering data sources other than plan submissions, to ensure capitation funds are flowing to behavioral health.
    - The Office acknowledged that the capitation allocation methodology is an estimation of behavioral health spending under capitation and that the Office recognizes the limitations of using encounter data. The Office noted that it instructs payers to use plan-specific fee-for-service equivalents rather than a standardized Medicare rate or other rate. OHCA will continue discussions of collecting data from risk-bearing organizations or other ways to evaluate the capitation amount going to behavioral health.
- A member asked what tools would best equip OHCA to include an estimation of out-of-pocket spending in the behavioral health spending measurement.
    - The Office stated that out-of-pocket, out-of-plan spending will not be included in the behavioral health spending measurement, which comes from the total medical expense data provided by the plans. OHCA is working to conduct separate analyses to estimate behavioral health out-of-pocket, out-of-plan spending, including extrapolation based on Medical Expenditure Panel Survey (MEPS) data. The Office noted they are encountering challenges such as needing to make many assumptions and pooling data across multiple years. OHCA will update the Board in the future about the status of those analyses.
- A member supported earlier comments from other Board members on creating incentives that encourage the integration of primary care and behavioral health. On the complexities of overcounting or undercounting behavioral health in primary care, the member sees greater harm in undercounting than overcounting. The member supported incentivizing primary care providers to obtain the necessary training to provide behavioral health services, and wants to see the benchmark to push behavior in that direction.
- A member expressed agreement with excluding mobile and long-term care from OHCA's behavioral health reporting subcategories, but emphasized the importance of tracking spending trends by subcategory in the broader market to better understand behavioral health spending trends over time. Perhaps mobile services account for so little spend because they are cheap and efficient; we should be supporting effective, efficient delivery and in order to do so we need to track trends in the market.
- A member supported not having mobile services and long-term care as separate reporting categories, as the HPD can track this data.
- A member supported the integration of behavioral health and primary care, but was wary of including in the measurement any service with a secondary behavioral health diagnosis, especially for inpatient settings, because the behavioral health condition may not be the primary condition being treated.
- A member referenced OHCA's work with MEPS and expressed appreciation for that work but asked for a timeline for another strategy to understand behavioral health out-of-pocket, out-of-plan spending. The member suggested surveying

therapists and other behavioral health providers about how much of their revenue comes from out-of-pocket payments.

- A member requested for a timeline for when behavioral health spending from county mental health plans will be included in the measurement, given that this is an important part of the behavioral health landscape in California.
- A member was unsure whether to include or exclude secondary diagnoses in the primary care setting and provided an example of secondary behavioral health diagnoses in FQHCs where providers cannot bill for both physical and behavioral health on the same day, even though patients often present with both on the same day. The member noted that it's likely providers bill for medical services alone even when they also provide behavioral health services. The member asked if there is a methodology to qualify secondary diagnoses for inclusion in the measurement, since we will likely miss a lot of behavioral health care by counting only the primary diagnosis.
- A member supported implementing a timeline for including county mental health in the measurement since it is an important part of the delivery system. The member also supported integration of behavioral health with primary care and emphasized that the methodology should not disincentivize integration efforts, given that increasing the amount of behavioral health care delivered in primary care may be the only way to reach access goals.

Public comment was held on agenda item 5a. Three members of the public provided comments.

Agenda Item# 3: Action Consent Item
Vishaal Pegany, Deputy Director, HCAI

Vote to Approve the June 9, 2025 Meeting Minutes

Deputy Director Pegany introduced the action item to approve the April meeting minutes. Dr. Sandra Hernández proposed a motion to approve, with a second from Richard Kronick.

Public comment was held on agenda item 3. No members of the public provided comments.

Voting members who were present voted on item 3. There were four ayes and two members abstained. The motion passed.

Agenda Item #4: Action Item
Megan Brubaker, Engagement and Governance Group Manager, HCAI

Vote to Appoint Advisory Committee Members

Megan Brubaker introduced the action item to appoint the Advisory Committee members and provided a review of the submission process, the applicant pool, the committee positions requiring appointments, and the subcommittee's recommendation.

Dr. Sandra Hernández proposed a motion to approve, with a second from Ian Lewis.

Public comment was held on agenda item 4. One member of the public provided comments.

Voting members who were present voted on item 4. There were six ayes. The motion passed.

Agenda Item #5: Informational Items
CJ Howard, Assistant Deputy Director, HCAI
Vishaal Pegany, Deputy Director, HCAI

5b) Timeline of Changes under Federal Budget Reconciliation (H.R. 1)

Chair Johnson introduced item 5b and noted that an overview of changes resulting from H.R. 1 is available on the California Health and Human Services Agency website. She further highlighted that the bill is expected to result in significant funding reductions—estimated at more than $30 billion—and impact over 3.4 million Californians. Deputy Director Pegany provided an overview of the timeline of changes under H.R.1.

Discussion and comments from the Board included:

- A member asked whether OHCA can address the upcoming Medicare cuts resulting from sequestration under existing federal law, which are triggered by the increase in income.
    - The Office replied that it will monitor Medicare sequestration and will report back to the Board any new information. The Office noted that prior sequestration triggers have been delayed by Congress.
- A member emphasized the importance of monitoring the number of people insured via Medi-Cal, Medicare, and commercial insurance, as well as the number of uninsured in California as a result of the federal legislation and its impact on affordability. The member stated that changes in federal and state law should be factors in the cost target setting and in response to entities who exceed the targets.
- A member noted the H.R. 1 is being implemented in a context where federal policies are specifically targeting people of color and immigrant communities, making it dangerous for people to go to work and therefore jeopardizing their employment-based health insurance. Immigration actions are also targeting health facilities and neighborhoods near health facilities. Fear creates another barrier to accessing care which affects commercial and employer-based plans, as well as public plans.
- A member commented that using H.R. 1 as an excuse to raise prices on commercial payers by allowing providers to increase rates at will to offset or

recoup the money they are losing in other lines of business amounts to an unlegislated tax increase. The member encouraged OHCA to follow through on the targets that have been set.
- A member noted that in addition to H.R. 1, new CMS regulations could significantly impact California's primary care capacity if the way in which federally qualified health centers can approach care delivery changes. We must track the federal regulatory environment in addition to the impacts on county infrastructure and how federal immigration policy overlaps and undermines California's health care goals.
- A member stated that despite the cruelty of H.R. 1, it should make it easier for California entities to make the 3.5% cost growth target. as it takes money out of the overall health care system and will result in lower spending. The law is not a rationale for exceeding the target.

Public comment was held on agenda item 5b. Two members of the public provided comments.

5c) Discussion of Data Submission Enforcement

Assistant Deputy Director Howard provided an overview of the data submission enforcement, including the statutory requirements, a potential penalty structure and process, and timeline for next steps.

Discussion and comments from the Board included:
- A member provided an example of federal hospital transparency reporting rules in which penalties in the first year were nominal and there was almost no compliance. The member encouraged OHCA to adopt a penalty that will be significant enough to encourage compliance. The member also noted new regulatory approaches to enforcement at the federal level on data reporting and transparency that may help.
- A member asked how much lead time the entities have prior to the September 1st deadline to understand the data submission standards.
  - The Office responded that data standards are found in the data submission guide (DSG). DSG regulations were promulgated in March or April and were socialized several months before that; therefore, approximately six months.
- A member questioned the logic of giving an entity an extra 30 days to submit their data if they already had more than six months and wondered about scenarios in which the entity could then act differently and turn in the data within 15 to 30 days.
  - The Office replied that many entities did submit their data by September 1st, and OHCA had approximately 80% compliance by the end of October. Entities were likely working through their final checks prior to submitting.
- A member suggested requiring a data submission plan earlier in the process after an entity failed to submit timely data. Regarding the penalty structure, the member also suggested charging a significant penalty for the first year that an entity does not submit data. If they fail to submit again the following year, the

penalty would be doubled and would continue to be doubled each year until they do submit data as at a certain point it becomes willful noncooperation.

- A member commented that $5 per member intuitively seemed substantial enough to act as a deterrent but suggested a penalty that tolls month to month or week to week rather than year to year and questioned if the Office contemplated this type of structure verses a one-off penalty.
  The Office responded that the proposed structure is partly for simplicity while also balancing the operational needs of the program to meet its data aggregation and reporting requirements. There are a couple of cliffs in the reporting process which could harm the ability to generate the annual report but the harm does not necessarily go up on a daily basis.
- A member suggested a need for an ongoing penalty since if a penalty ends, there is no financial incentive for submitting data; some incentive should be kept. The member also asked whether a penalty would be imposed for the submission of incomplete data, for example blank files or data that is just not good enough.
  - The Office responded that the DSG has a five-day carve out period where once the data is submitted the entity can correct discrepancies. This would be integrated into the penalty process.
- A member asked about the timing of the review process.
  - The Office replied that automated checks are conducted quickly while OHCA's more detailed checks typically takes one to two business days. OHCA will confirm the timing and will report back to the Board at the next meeting.
- A member appreciated the option for public testimony, as public transparency creates another motivation for entities to submit on time and is an important component. The member also asked what else could be done, in addition to financial penalties, for an entity that refuses to submit data year after year.
  - The Office stated they could pursue other legal remedies or action, as an entity who refuses to submit the required data would be violating state law.
- A member questioned whether OHCA has the authority to compel an entity to attend a public hearing.
  - The Office responded that they have subpoena authority.
- A member asked whether OHCA has received any feedback from the plans regarding the data submission requirements and deadlines.
  - The Office shared that they have had some initial discussions with plans. The plans generally ask for changes to the DSG to be socialized and put into regulation earlier due to their required system changes. OHCA is mindful of that and aims to provide a minimum of six months' lead time. The Office also noted its efforts to consult with the plans through the data submission workgroup and test file submission opportunities. Additionally, OHCA noted that they are receiving data from the commercial and Medicare plans and have been obtaining the Medi-Cal data from DHCS. OHCA will work closely with the Medi-Cal plans that may not already be data submitters.
- A member commented that the penalty proposal is reasonable but that, for example, an entity that repeatedly fails to comply with the submission

requirements, the penalty must go beyond the cost of doing business as it could compromise the charge of the Office.
    - The Office responded that it appreciates the Board's input and the need to address repeat offenders.

Public comment was held on agenda item 5c. One member of the public provided comments.

5d) Introduction to Spending Target Enforcement and Timeline

Assistant Deputy Director Howard and Deputy Director Pegany provided an introduction to spending target enforcement, as well as a timeline for future discussion. Deputy Director Pegany then provided a summary of OHCA's engagement on high-cost drugs.

Discussion and comments from the Board included:

- A member asked for clarification regarding technical assistance that OHCA will provide to entities who exceeded the cost target, including what it is, how much time an entity will have to implement it, how OHCA will evaluate whether the entity followed it, what OHCA's responsibility is if they follow it in addition to a performance improvement plan (PIP), and are still over the cost target. OHCA would essentially be telling the entity how to run their entity. The member asked what this could mean in terms of compliance and the consequences for the entity.
    - The Office replied that there will be a more detailed discussion about technical assistance in a future meeting as this presentation provides a general overview of enforcement considerations. The Office also clarified that if an entity does undergo a PIP, the entity would be responsible for proposing improvement strategies which they would discuss with OHCA prior to OHCA bringing the PIP to the Board for review and input; OHCA clarified that it would not be running the entity's operations.
- A member cautioned OHCA about bringing PIPs to the Board, stating that it would not be practical considering the large number of entities that will initially miss the target, and is also not the role of the Board.
    - The Office stated that under the statute that the Board provides input on PIPs. This could occur in a closed session. The Office also clarified that not every entity would move to a PIP and that before they can address what a PIP entails, what technical assistance may involve, or what penalties may apply, they must first determine how to assess performance and what OHCA should take under consideration, high-cost drugs being one example.
- A member questioned why enforcement is already being undermined before a challenge is encountered. The member would only consider supporting acts of God or catastrophic events on the list but cautioned anticipating problems and undercutting the role of OHCA. The member also expressed discomfort with providing technical assistance.

    - The Office clarified OHCA will provide a more detailed discussion of what technical assistance means but that staff will not be advising entities how to operate their organizations.
- A member recommended that OHCA be very narrow in any exceptions to the targets and only on a case-by-case or year-by-year basis with an independent analysis of differential impacts across the health system and sectors within it.
    - The Office clarified that the considerations would not be automatic. The entity would need to submit compelling data that would demonstrate they would have reached the target had it not been for a specific factor; the onus is on the entity.
    - A member responded that there will be high-cost drugs and entity claims of investments in primary and preventive care but feels it is a slippery slope to undermine the target.
- A member commented that, if OHCA believes high-cost drugs will be a systemic problem, then they should revisit the 3.5% target. The member stated that the change in federal law is a reason to reduce the target rather than to increase it. The member cautioned against catalyzing the consulting industry to justify exceeding the target and does not recommend following Oregon's approach.
    - The Office responded that they have heard Oregon's list is too broad.
- A member cautioned against providing a blanket waiver but that OCHA can ask how factors led to the entity exceeding the target.
    - The Office clarified that the reasonable considerations are different from the enforcement considerations. The waiver is provided at OCHA's discretion and can only be provided when there are extraordinary circumstances which suggests limited factors.
- A member suggested entities should be asked to compare the effects at their institutions to statewide and stated that the increasing cost of drugs should not justify exceeding the target as the cost of drugs are increasing everywhere.
- A member commented that the point is affordable health care, not how to give everyone a pass for not creating affordable care.
- A member stated that the recent changes to federal law are not minor adjustments to the Medicaid and Medicare programs; these are some of the most significant changes to these programs since the ACA passed. They also commented that the cost target is based on median household income. If a drug expense increases more than the median household income, then it will be the entity's decision whether to provide access to that medication so access could be impacted.

- A member commented that the lack of affordability had been increasing in the health care industry pre-ACA when the uninsured rate was in double digits. As we now face a rollback of ACA, we will see more uninsured individuals and access will be reduced; this is not due to the spending targets. H.R. 1 will require significant adaptation for the entire health care delivery system; however, affordability has been an ongoing issue prior to the ACA. OHCA should not allow H.R. 1 alone to enable the delivery system to take a pass on the spending targets.
    - A member recalled previous public testimony where a chemotherapy infusion was purchased through the 340B program at approximately $150 for the entire

course, Medicare would have reimbursed for about $185, and yet the negotiated rate that the hospital received for the treatment was over $80,000. When talking about cost, which of these numbers is a cost and for which entity? It would be helpful to understand how we think about that.

- A member stated that while occasionally new high-cost drugs are released, roughly half of all drugs decrease in cost each year. However, that reduction in cost is rarely passed on to the purchasers or consumers. This highlights the opportunity for those in the health care system to pass on those savings.
- A member expressed surprise that, despite being led by smart, well-paid executives, none of these entities have any ideas to address the problem and they all claim they lack control. Why would we pay them to manage a problem they do not understand. PBMs, who are tasked with managing drug costs, stated they are unable to do so. Health plans claimed they cannot manage the PBMs—despite the fact that they own them. Ultimately, every entity involved, except the consumers, have a financial incentive for costs to continue rising. There are business practices behind these cost increases that must be addressed or there is not much OHCA can do.
- A member commented about certain policy decisions made about drug investment and development, patent protections, and price. At a certain point, if people want the drug, then that is the cost. Entities have the choice to make it available.
- A member commented that PhRMA is not listed as one of the constituent groups that OHCA met with, yet they are a large contributor to the high drug prices.
- A member suggested exceptions for exceeding the target should be extraordinarily sparing and gave examples of GLP-1s and new cell or gene therapy impacts; the former likely has a broad system impact and would not be a reason for an entity to exceed the target while the latter, if for example, was offered by two institutions at $5 million each, then it could possibly be considered.
    - The Office considered the member's earlier comment about drug costs not affecting everyone in the same way. While gene and cell therapy are expensive, larger plans may be able to distribute that cost across all members to avoid exceeding the cost target. OHCA heard in their meetings with health plans that GLP-1s are a higher cost because more people use them and wondered how to think about that.
    - The member suggested that something broad, like GLP-1s, might be a reason to reconsider the targets but to not provide plan-by-plan exceptions.
- A member asked for reflections on the National Academy for State Health Policy's (NASHP) Hospital Cost Tool.
    - The Office indicated that they have begun reviewing the tool and plan to conduct a more in-depth analysis. It is similar to the data presented for the Commercial to Medicare cost ratio and can provide a deeper dive into what commercial entities pay for drugs versus what Medicare pays. It also can be a gauge for the appropriateness of reimbursement.
- A member asked if the database gets to how much a drug actually costs versus price.

    - The Office replied the database has Medicare and if it presents a ratio, the Medicare payment can be determined, which is closer to cost. Drug prices in general are harder to tease out but other databases have the list price.
    - Another member commented that list prices are so unmoored that it likely will not produce a meaningful analysis.
- A member raised concern that if a new product—such as a life-saving anti-cancer drug—emerges with a strong need for immediate access, an entity would face a difficult choice: either provide the drug and exceed the cost target or deny access to the drug altogether.
    - A member responded that this will always be the case and commented that if it is important and material, the cost target should be changed but doing it on an entity-by-entity basis is counterproductive and a waste of resources.
- A member recommended that every year at a specific time, OHCA should present the Board with a list of items that would fall under the definition and should then reassess the cost target.
    - A member expressed support for this recommendation, while another member expressed that they do not support this.
- A member suggested that OHCA meet with purchasers who have proven to be successful at managing drug costs, such as self-insured large employers, to learn from their experiences.

Public comment was held on agenda item 5d. Eight members of the public provided comments.

Agenda Item #6: General Public Comment

Public comment was held on agenda item 6. No members of the public provided comments.

Agenda Item #7: Adjournment

Chair Johnson adjourned the meeting.