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

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HEALTH CARE AFFORDABILITY BOARD

MEETING MINUTES
Monday, June 9, 2025
10:00 am

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

Members Absent: Elizabeth Mitchell, Dr. Richard Pan

Presenters: Elizabeth Landsberg, Director, HCAI; Vishaal Pegany, Deputy Director, HCAI; CJ Howard, Assistant Deputy Director, HCAI; Andrew Feher, Research and Analysis Group Manager, HCAI; Margareta Brandt, Assistant Deputy Director, HCAI; Debbie Lindes, Health Care Delivery System Group Manager, HCAI

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

Agenda Item # 1: Welcome and Call to Order
Chair Secretary Kim Johnson, HCAI
Elizabeth Landsberg, Director, HCAI

Chair Johnson opened the June 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.

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

Director Landsberg provided Executive Updates, including the following:

- A recognition of June as Pride month, as well as HCAI's focus on diversity and equity.
- An acknowledgement and appreciation for the work done by OHCA's data team for having prepared the Baseline Report which has been published with the Legislature and on the HCAI website.

- A recognition of the challenges presented in collecting the data related to dual eligible individuals and the many complicated Medi-Cal spending streams.
- An update that HCAI will not be moving its headquarters this summer as previously announced. All ongoing Board and Advisory Committee meetings will be held at 2020 West El Camino Avenue in Sacramento.
- An update on the Governor's May Revision, which revealed a $12 billion state budget deficit. The revised budget proposals for HCAI include:
    - Investing approximately $1.9 billion over five years in the behavioral health workforce under the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-Connect) waiver.
    - Requiring Pharmacy Benefit Managers (PBMs) to be licensed by the Department of Managed Health Care (DMHC) and to provide data to HCAI's Health Care Payments Data (HPD) program. HCAI would receive funding for staff positions that support the oversight of PBMs to better understand costs, with the goal of ultimately improving the affordability of prescription drugs in California.
    - Expanding the authority of HCAI's CalRx program to partner with brand name drug manufacturers, allowing the state to respond to supply chain disruptions, market manipulation, and reduced access to essential medications, including those for reproductive health.
    - Allocating $90 million of Proposition 35 funds for HCAI to administer reproductive health investments for emergent needs which could include midwifery loan repayments and scholarships and education capacity expansion for midwives.
- An update that the HPD program is moving forward in the collection of Non-Claims Payment data. Non-claims payments are payments that are not on a fee-for-service basis, including capitation payments and rebate information. HCAI will be using a new national standard for collecting non-claims payment data.
- An announcement about HCAI's recent distribution of $38 million in awards through three workforce development programs to equip peer specialists and behavioral health professionals with the tools they need to deliver behavioral health services in California.

Deputy Director Pegany provided Executive Updates, including the following:

- A review of two recent articles published in Health Affairs.
    - The first article examined the positive feedback loop in hospital prices related to capital expenditures, finding that hospitals investing more in capital infrastructure gained market share and raised prices, while hospitals investing relatively less in capital lost market share and had fewer price increases.
    - The second article evaluated the financial impact of Rhode Island's strategy to curb hospital prices and its effect on enrollee premiums and hospital margins in the commercial market between 2010 and 2022.
- A response to a Board request to review 2023 key economic indicators to assess whether the statewide spending target, which is based on 2002-2022 data, remains

appropriate. Results showed that two indicators, California median household income and the Medicare Economic Index, rose 0.1 percent over the 2003-2023 average while the Consumer Price Index for California showed no change. OHCA concluded that these updated figures continue to support the three percent spending target as a reasonable and appropriate benchmark.

- Information about the Commercial to Medicare Payment to Cost Ratio (PTCR) coding correction. PTCRs were originally calculated using Python code but in mid-May staff created Stata code and found the output differed from that previously publicly shared. Staff found a discrepancy related to therapeutic cost centers, recalculated the PTCR data, and determined that the set of hospitals deemed high-cost did not change, nor did the proposed sector target values change for those high-cost hospitals. OHCA has updated the publicly available hospital-level dataset on its website and included in the presentation's appendix how previously reported PTCRs differ from the updates.
- An update on pharmaceuticals and affordability, providing background information and an overview of the factors impacting growth in retail drug spending, and how OHCA and HCAI are responding.
- A reminder about slide formatting.

Discussion and comments from the Board included:

- A member asked Deputy Director Pegany about any federal prescription drug changes to highlight.
  - The Office replied that it is monitoring executive orders from the Trump administration, including accelerating the approval of new drugs to market and for PBMs, the federal definitions and language used.
- A member asked how the PTCR error was discovered and appreciated the Office's transparency about rerunning the numbers.
  - The Office explained it discovered the coding error in May when preparing to analyze future years' data using Stata. When OHCA replicated its existing data set using Stata, they noticed small discrepancies in the values. This prompted an internal investigation with their external consultants and led to finding an oversight in the consistent consideration and application of therapeutic cost centers in the external consultant's Python code initially used to develop outputs. The Office noted the error was initially made by a contractor and that they have discussed quality control.
- A member asked regarding prescription drug affordability, if in addition to state efforts to align CalPERS, Medi-Cal, etc., there had been any discussion about aligning private purchasers and payers around a common formulary to extend the reach of the initiative.
  - A member recollected that CalRx was in part the outcome of a coalition of public purchasers that met early in the first term of the Newsom administration. They also mentioned efforts among public purchasers who are part of the Purchaser Business Group on Health supporting legislation at the federal level and opined that the biggest challenge on the drug side is that PBMs only offer self-insured products to avoid exposure to potential losses and that state law is limited.

    - The Office confirmed early efforts to do bulk purchasing among the Department of General Services (DGS), CalPERS, and Covered California, resulting in contracts with the University of California that led to savings by using DGS's ability to contract. The PBM licensure and data collection is the more active proposal.
- A member commented, in reference to slide 10, that although drug prices have increased more than anything else in the last 60 years, in the last 15 years from 2005 to 2020, drug price increases were not the big drivers of overall healthcare costs. While attention should be paid to drug prices, the focus needs to be on increasing costs in the broader health care system.

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

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

a) Approval of the April 22, 2025, Meeting Minutes

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

Public comment was held on agenda item 3. One member of the public provided comments.

Voting members who were present voted on item 3. There were three ayes, one member abstained, and two members were absent. The motion passed.

Agenda Item #4: Informational Items
Vishaal Pegany, Deputy Director, HCAI
CJ Howard, Assistant Deputy Director
Andrew Feher, Research and Analysis Group Manager
Margareta Brandt, Assistant Deputy Director
Debbie Lindes, Health Care Delivery System Group Manager

a) Presentation of the Baseline Report

CJ Howard provided background on the data collection engagement for the 2022-2023 Baseline Report. Deputy Director Pegany presented a high-level overview of the report. Andrew Feher provided more detailed breakouts of Total Health Care Expenditure (THCE) and Total Medical Expense (TME) data.

Discussion and comments from the Board included:
- A member requested clarification of the Medi-Cal managed care timelines for data submission and its complexities.

    - The Office explained that there is a lag between when OHCA can process commercial and Medicare Advantage data, which is available in the fall, and Medi-Cal managed care organization (MCO) data currently received from the Department of Health Care Services, using medical loss ratio reports, that are not finalized until spring.
- A member asked if OHCA envisioned the ability to collect data directly from Medi-Cal managed care plans.
    - The Office replied that it had temporarily granted Medi-Cal MCOs a delay from directly reporting data to OHCA as a means of reducing administrative burden. Next year, they will directly submit alternative payment model and primary care data. As OHCA builds out the program, we will likely need direct data collection, especially for provider-level reporting to physician organizations and the attribution it requires.
- A member expressed concern about possible discrepancies in the data that show only a 2 percent difference between THCE and TME for Medicare, suggesting that the 2 percent covers all administrative costs.
- A member suggested that HCAI focus on the cost drivers of the 25 percent increase in administrative cost and profit in health plans and how these increases compare to rising administrative costs of health plans in other states.
- A member suggested that both Medicare and dual eligibles be listed as a single category and then also be separated so that spending levels and growth rates could be compared between traditional Medicare and Medicare Advantage.
    - The Office explained that while attributing the dual eligible spending between Medi-Cal and Medicare is a complex undertaking, it is achievable with the inclusion of data from Dual Special Needs Plans (D-SNPs).

Public comment was held on agenda item 4a. Three members of the public provided comments.

b) Update on Measuring Hospital Spending

Deputy Director Pegany summarized the progress made on hospital measurement and outlined the objectives of the work group when it reconvenes this summer.

Discussion and comments from the Board included:

- A member asked if one output of this work group would be to better tease out the administrative costs and profits of the sectors so that this data could be layered on top of the payer administrative costs and profits in future reports.
    - The Office replied that the hospital measurement will focus specifically on net patient revenue for care delivered, so it's about payments from plans to providers, and this revenue does include administrative costs and profits. This information could also be teased out in a different way utilizing data obtained from the financial statements filed by hospitals and health plans, such as revenue and expenses or non-operating revenue separate from patient care.

- A member asked if there was an intention to combine the inpatient and outpatient data as one measurement or to have separate targets for each one.
    - The Office stated that there is an ongoing conversation about that. The goal is to have a combined measure while also having distinct inpatient and outpatient measures that will allow for monitoring the changes related to shifts from inpatient to outpatient care by payer type.

Public comment was held on agenda item 4b. Four members of the public provided comments.

c) Update on Behavioral Health Definition and Investment Benchmark

Margareta Brandt and Debbie Lindes presented an update on the behavioral health work stream, including analyses of behavioral health spending data that has been shared with the OHCA Investment and Payment Workgroup, an overview of the behavioral health investment benchmark proposal, and a new recommendation to focus on data collection and measurement before setting a benchmark.

Discussion and comments from the Board included:

- A member asked about where telehealth fits within the behavioral health spending subcategories.
    - The Office explained that telehealth services would be included in the respective subcategory they apply to but generally they would fall into the outpatient professional non-primary care category.
- A member was interested in better understanding what contributes to the approximately 2 percentage point difference in behavioral health spending between HPD and both Covered California and CalPERS.
- A member asked if there is a large differential between plans that provide a lot of capitated behavioral health versus plans that are heavily or entirely claims based. The member also asked what percentage of total claims spend is screening as opposed to ongoing delivery of care.
    - The Office replied that screening services have a CPT code, and the associated spend is separate from the total spend of the visit and is often zero.
- A member asked if HCAI can use HPD data, with a focus on equity, to stratify the analysis by demographics or geography.
    - The Office explained that the HPD contains good geography data but is lacking sufficient race ethnicity data. HCAI has not publicly reported race ethnicity data, but it hopes to do so in the future.
- A member asked why the HPD analysis was restricted to commercial plans and did not include Medicare Advantage and Medicare.
    - The Office replied that this was a preliminary analysis, and restricting to commercial was more comparable to Covered California and CalPERS data. There is an opportunity in the future to look at Medicare Advantage data.

- A member asked for clarification on the criteria for inclusion or exclusion of encounter data in the numerator and/or denominator.
  - The Office stated that this analysis was based on claims data that was used for both the numerator and the denominator. No encounter data was included.
- A member asked if future analyses would include Medi-Cal data and if county specialty mental health data would also be included.
  - The Office replied that it intends to include Medi-Cal data eventually. Its recommendation is to move forward with collecting behavioral health spend data from Medi-Cal managed care plans and to continue to work with the Department of Health Care Services (DHCS) to understand the broader behavioral health spending across the Medi-Cal delivery system.
- A member asked about plans to understand behavioral health spending in the corrections system.
  - The Office stated that spending data for correctional health was included in THCE in the baseline report. This data could be further analyzed to understand if more detailed data on behavioral health spend is available, but it would not be included in the benchmark.
- A member expressed interest in understanding out-of-plan spending and suggested that a survey be done among therapists to understand their revenue structure, particularly as it relates to out-of-pocket payments, as one way to learn more about this spending.
- A member supported OHCA's recommendation to delay setting a benchmark given the data gaps that exist.
- A member expressed concern about getting an accurate assessment of what share of capitated or non-claims-based payments is attributable to behavioral health.
- A member asked if there was a way in which setting this benchmark could be used to drive compliance with California's timely access laws.
  - The Office stated that, along with the work by DMHC and DHCS, increased investment in behavioral health should help with timely access.
- A member expressed concern that imposing spending thresholds on static supply may create supply challenges and increase unit prices and recommended monitoring this.
- A member supported some delay in setting the benchmark, but was not sure about a three-year delay versus a one- or two-year delay, and wondered if the measurement should rely on using the HPD data to reduce the delay, versus the data OHCA will be collecting from plans. The member suggested that proxy data could be applied to encounters in HPD with no associated spending data. The member noted that determining what fraction of capitation payments goes to behavioral health will always be difficult and that estimating that spending using encounter data may be a better approach.
  - The Office replied that collecting data directly from plans will enable the Office to collect behavioral health non-claims data from the payers in addition to capitation, such as pay-for-performance or infrastructure payments supporting behavioral health, though the amount of these payments might be small. The Office could potentially use HPD to analyze data to make recommendation for a benchmark sooner rather than waiting to collect data from the plans.

- A member noted that because non-capitation non-claims spending amounts are low in the baseline report, accounting for these small payments may not be a strong reason to use plan data rather than HPD.
    - The Office responded that in addition to including the other non-claims payments, a reason to use plan data is to use the plans' analyses of their allocation of capitation spending to behavioral health, rather than a methodology set by OHCA to analyze HPD data.
- The member noted that an OHCA methodology would be more uniform, and possibly more accurate, than plans attempting to follow instructions, and noted that using HPD has a lot of advantages including reducing the delay before setting a benchmark can be set.
- A member strongly recommended collecting specialty mental health data sooner rather than later because of the large amount of spending and high acuity of the populations in county plans. The member also suggested that HCAI could create a summary of other behavioral health reforms underway including dollar amounts going into those programs and expected outcomes.
- A member commented that the ability to understand the impact of many changes happening in the overall behavioral health landscape is very important.
- A member asked for a review of what we know about behavioral health benchmarks in other states.
    - The Office replied that Massachusetts monitors behavioral health spending but does not have a behavioral health investment benchmark. The only state that has set a behavioral health investment benchmark is Rhode Island, and performance results have not yet been reported.
- A member asked about the timeline for setting the benchmark and next steps for the Board on this topic.
    - The Office replied that it would not be setting a benchmark this summer. There are no action items for the Board in the near term. The Office will begin to collect data and will provide updates to the Board next year.
- A member asked if Rhode Island would have the results of the benchmark survey in 2025, as this is the third year of that survey and requested clarification of next steps.
    - The Office replied that it may take until late 2026 or early 2027 to have those results because of the claims run out period. The Office will bring the results to the Board when they become available. The proposed next steps are to finalize the definition of behavioral health spending, to collect behavioral health spending from commercial, Medicare Advantage, and Medi-Cal managed care plans while continuing to work with DHCS. The Office can also analyze HPD data and come back to the Board as soon as feasible with more information.
- A member commented with a hypothesis to understand the differential in behavioral health spending between CalPERS, Covered California, and HPD – CalPERS benefits are more generous, so the behavioral health spending may be a smaller percentage of total spend, but this is not what the data shows so it's hard to understand why Covered California has the lowest behavioral health spend percentage.

    - The Office replied that the same specifications had been used for all three data analyses and that they will work with CalPERS and Covered California to further understand the differences in trends across the three data sources.
- A member commented that differences in the use of capitation or differences in health status of the covered populations could explain some of the differences between these data sources.
- A member advocated for the Office to look at spending using HPD for Medicare Advantage and Medi-Cal, and to study the feasibility of using proxy spending to estimate spending for encounters. The member also supported incorporating county specialty mental health spending into the analysis.
- A member noted that a large amount of behavioral health care, especially at Kaiser, is paid via capitation. The member also noted related to the prior comment about driving up unit price that unlike other sectors in health care, such as hospitals, the norm for payment of commercial behavioral health services is around 90% of Medicare, so some increase in unit price may be necessary to fix the labor market problems. When we set a proxy for encounters we would need to take this into account, as well as variation across payers, geographies, and patient populations.

Agenda Item #5: General Public Comment

Public comment was held on agenda item 4c and agenda item 5. Two members of the public provided comments.

Agenda Item #6: Adjournment

Chair Johnson adjourned the meeting.