HCAI
Department of Health Care Access and Information

THE DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION

Office of Health Care Affordability

Health Care Affordability Board
March 21, 2023 Meeting
Written Public Comment

The following table reflects written public comments that were sent to the Office of Health Care Affordability.

Date	Name	Written Comment
3/19/23	Gerald Rogan	Thanks for sharing. I reviewed your slides. The slides do not disclose what Massachusetts did to succeed. i recommend you develop a method to identify and measure medically unnecessary services. For example, most ankle sprains do not require an X-ray on the first visit. Most emergency department visits can be served through an urgent care center. Some urgent probelms which nursing home patients incur, such as a fall, can be evaluated in the facility without a visit to an emergency department. I suggest you track emergency department visits from NHs and SNFs of patients who return to the facility the same day. Review the cases to detemine how many only needed a practitioner to come to the facility. Review ankle-sprains in the ED. Measure the percentage of fractures. A reliable test for a fracture is to strike up against the sole of the foot. If no pain is produced, an X-ray can be postponed and perhaps avoided entirely. How many x-rays were unnecessary? How many patients receive an MRI for low back pain without a medical need. I had to write an LCD for Medicare to contain abuse of MRIs for LBP in 1999 to control overutilization. It worked. Data collection should include measurement of waste, and fraud. Your plan must focus on methods to reduce medical waste and abuse in order to be effective. Has any State done this? If you want me to consult to your panel, ask me for my CV.
3/20/23	Gerald Rogan	I read your slide deck a second time looking for actionable ideas. If you are focused on Medi-Cal, two former Medicare Medical Directors, myself and a colleage believe you cannot reduce provider fees more, so the only open direction to control expeditures is in the direction of efficiency as I describe below. Examples: --diagnose correctly on the first visit. -- use clinical judgement more with fewer tests

Date	Name	Written Comment
		-- reduce the fees for overpriced services like ??? -- Treat patients in a less costly place of sevice -- prescribe equally effective cheaper drugs -- prescribe fewer drugs In addition, you can analyse data to discover inefficient providers then make recommendations. Attachment: https://drive.google.com/file/d/1efmn4V4M2dfZw9vbWdUhmILaqUVLX2O7/view
3/21/23	Katherine Sullivan	Dear Board, I am Dr Katherine Sullivan who is a State of California licensed healthcare professional in good standing since 1987. The transformation of the California healthcare system can be accomplished if we investigate strategies to create a high complexity cases which include seniors 65 yrs and older to under 65 yrs and on Social Security Disability Income. Any Federally-protected populations which includes veterans, children and adults with developmental disabilities, adults who are 18-64 yrs who have sustained injuries or have physical or mental limitations because of a disease such as Cancer, COVID, or addiction disorders. The growing number of Californians who are falling below 200% of the Federal poverty level are qualified for Covered California the public health managed care agencies such as the Inland Empire Health Plan in Riverside County or LA Care in Los Angeles will not open up to specialty provider groups such as 360 Wellness Solutions. 360 Wellness Solutions is a Medicare-qualified, rehabilitation and behavioral health multi-professional group that is qualified to provide complex care case management and care coordination to California managed care beneficiaries who meet the requirements for complex care. This is a NEW model for the country that is based on objective criteria of mental or physical disability. This model would separate from the total population State of California managed care beneficiaries who have 2 or more falls with injuries in the past 6-month, 2 or more hospital, ER, or urgent care visits in a month, evidence of failure to thrive (loss of 10 lbs or more in the past 6-mos - 12-mos), a dementia score of 24 or lower on the MMSE, or homeless. We are in a existential crisis but more than that we are in a humanitarian crisis. The concerns of the public are the concerns of the public in poverty. I have been trying for 8-yrs to create a new approach to population health that is based on a rehabilitation model that analyzes total cost of case per year. I have worked with incredible public health physicians like Dr Richard Katz, Dr David Carlisle, and Dr Mark Ghaly. The limitation is not those of us who are licensed healthcare

<table>
<tr><th>Date</th><th>Name</th><th>Written Comment</th></tr>
<tr><td></td><td></td><td>professionals. The limitation is in the payor community that will not entertain innovation in payment models for Californians who are in deep poverty bases on Federal Standards.</td></tr>
<tr><td>4/06/23</td><td>Anonymous</td><td>Hi Ms Landsberg and Director's office,
Hope you are well. I read in the news about the creation of the Office of Health Care Affordability within HCAI. I admire your commitment and service to the community on such complex and systemic issues. With the right guardrails and policies you could drive lasting impact for California for generations to come.
To do my minor part to help, I want to share my observations of El Camino Health's ER pricing from 2021-22 (see table and sources of data below). For the most common CPT codes in ER services (99282-99285, 99213), El Camino Health has increased the total charges by nearly 50% in one year for the top two codes (99282 and 99283). Not only this is a significantly higher increase than general inflation, they are now 50-75% more expensive than Kaiser in the same south bay area. Please also keep in mind the 99282 Level 2 ER visit is typically the "base" visit to an ER - anyone who walks into ER and sees a doctor for 5-10min would be charged with this CPT code for the hospital, on top of anything the doctor or treatment would cost. I do not believe the $2171 charge is a real reflection of the hospital's actual cost structure for such service, especially given other reputable hospital's pricing for the same CPT code.
A few constructive ideas for you to consider
- In addition to letting hospitals report estimated percent change at the aggregate total revenue level, ask them to provide the percent increase for each of the most common top 25 codes
- Drive policies to cap allowed annual increases for each individual procedure (at least the top ones)
- For the top services that have a large patient volume and broad impact to our community (e.g., common Evaluation and mgmt services, common outpatient procedures), do a real audit and comparison of hospitals in similar regions to determine what is truly "fair".
Getting these right are difficult and time consuming efforts, which is why we are where we are for our healthcare system. I sincerely hope you would help break barriers to make it easier, cheaper and more fair for us in California. Thank you for your efforts and commitment.
<table>
<tr><th></th><th></th><th colspan="3">El Camino Health (OSHPD Facility No: 106430763)</th><th>Kaiser Santa Clara (OSHPD Facility No: 106434153)</th><th></th></tr>
<tr><th>Evaluation & Management Services (CPT Codes 99201-99499)</th><th>2022 CPT Code</th><th>2022 Jul Chargemaster</th><th>2021 Jan Chargemaster</th><th>21-22 increase</th><th>2022 Avg charges, effective Jun 1, 2022</th><th>Charges diff between El Camino Health and Kaiser</th></tr>
<tr><td>Emergency Room Visit, Level 2 (low to moderate severity)</td><td>99282</td><td>2,171</td><td>1,484</td><td>46%</td><td>1,248</td><td>74%</td></tr>
<tr><td>Emergency Room Visit, Level 3 (moderate severity)</td><td>99283</td><td>3,749</td><td>2,522</td><td>49%</td><td>2,496</td><td>50%</td></tr>
<tr><td>Emergency Room Visit, Level 4 (high severity without signigicant threat)</td><td>99284</td><td>6,147</td><td>4,938</td><td>24%</td><td>4,160</td><td>48%</td></tr>
<tr><td>Emergency Room Visit, Level 4 (high severity with significant threat)</td><td>99285</td><td>8,927</td><td>8,370</td><td>7%</td><td>5,880</td><td>52%</td></tr>
<tr><td>Outpatient Visit, established patient, 15 minutes</td><td>99213</td><td>124</td><td>91.9</td><td>35%</td><td></td><td></td></tr>
</table>
Source files:</td></tr>
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Date	Name	Written Comment
		2021 El Camino Health chargemaster (from their own site): https://www.elcaminohealth.org/sites/default/files/2020-12/el-camino-hospital-chargemaster-01012021.xlsx **2022 El Camino Health chargemaster (from their own site)**: https://www.elcaminohealth.org/sites/default/files/2022-12/94-3167314_el-camino-hospital-mountain-view_standardcharges.ods **Kaiser Santa Clara's chargemaster (from HCAI Open Data Portal)**: https://hcai.ca.gov/data-and-reports/cost-transparency/hospital-chargemasters/latest-chargemasters/
4/17/23	Health Access CA	See attachment 1 below.

Attachment 1

BOARD OF DIRECTORS
Juliet Choi
Asian and Pacific Islander American Health Forum
Mayra Alvarez
The Children's Partnership
Cynthia Buiza
California Immigrant Policy Center
Ramon Castellblanch
California Alliance for Retired Americans
Crystal Crawford
Western Center on Law and Poverty
Lori Easterling
California Teachers Association
Jenn Engstrom
California Public Interest Research Group
Stewart Ferry
National Multiple Sclerosis Society
Aaron Fox
Los Angeles LGBT Center
Jeff Frietas
California Federation of Teachers
Alia Griffing
AFSCME
Kelly Hardy
Children Now
Joseph Tomás Mckellar
PICO California
Andrea San Miguel
Planned Parenthood Affiliates of California
Maribel Nunez
Inland Empire Partnership
Tia Orr
Service Employees International Union State Council
Lorena Gonzalez Fletcher
California Labor Federation
Juan Rubalcava
Alliance of Californians for Community Empowerment
Kiran Savage-Sangwan
California Pan-Ethnic Health Network
Joan Pirkle Smith
Americans for Democratic Action
Rhonda Smith
California Black Health Network
Sonya Young
California Black Women's Health Project

Anthony Wright
Executive Director

Organizations listed for identification purposes

April 17, 2023

California Health and Human Services Secretary Mark Ghaly, M.D.,
Chair
Health Care Affordability Board
Office of Health Care Affordability
Department of Health Care Access and Information
2020 W El Camino Ave
Sacramento, CA 95833

Re: The Implementation of the Office of Health Care Affordability

Dear Secretary Ghaly:

Health Access California, the statewide health care consumer advocacy coalition committed to quality, affordable health care for all Californians, offers comments on the initial meeting of the Health Care Affordability Board.

These comments are in multiple parts:

- First, the Health Access California principles on the work of the Board and Office.
- Second, further comments on the presentations at the initial meeting of the Health Care Affordability Board
- Third, we offer a preliminary discussion on the metrics and mechanisms for consumer affordability of care and coverage.
- Fourth, California is different: comments on California law, health care market, and resources that may be different than other states

Part One: California Consumer Goals and Guiding Principles for the Office of Health Care Affordability

Health Access offers the following principles and goals to ground the thinking of the Board and the Office as they will guide our advocacy on behalf of consumers and purchasers. While there may be debates on specifics and substantive details, the Office should work toward the following objectives:

1) Slow unchecked health care cost growth to benefit Californians and California as a whole.
2) Provide real relief to consumers from ever-increasing health care costs.
3) Advance health equity to serve California's values and the specific needs of our diverse communities.

4) Prioritize ongoing improvements in quality, access, and equity alongside cost.
5) Transform our health system to disrupt misaligned payment incentives that work against improving health and lowering costs.
6) Provide the public and policymakers with an “all in” comprehensive view of our health system.
7) Track trends and ensure transparency translates to action.
8) Offer tools for transformation to help the health industry to meet the goals of containing costs while improving value and equity.
9) Create meaningful accountability for health care affordability through progressive enforcement, including commensurate and escalating penalties
10) Center California consumers’ experience and voice in all deliberations and decisions.

The full detailed description of these goals and principles are attached as an appendix.

The debate about whether the growth target is 2.8%, 3.1% or 3.6% as in some other states is a debate about whether consumers, workers and other purchasers pay more to the most expensive health care system in the world or whether that money would be better spent on wages, retirement and other necessities of life. The same is true of debates about economic indicators and other measures that will impact the spending targets.

Your decisions on targets and indicators should be fair, factual, and data-driven as well as grounded in the impact of higher health care costs on consumers—directly in terms of premiums paid, copays and deductibles, indirectly in terms of income which means less for other needs from housing to food to utilities to education and retirement. Every dollar in health care cost growth allowed is a dollar out of Californians’ pockets that consumers need for other necessities of life.

Part Two: The March 21, 2023 Initial Meeting Presentation and Discussion

Promoting A Public Process

First, we very much appreciate receiving the materials for the Board meeting several days in advance. Different agencies have different traditions about how far in advance materials are provided. For instance, CalPERS provides all materials ten days in advance of its public meetings. Providing materials in advance assists the Board as well as stakeholders time to better engage with this process.

Second, we also appreciate, on behalf of consumers and other purchasers, the additional opportunities for public comment that were added to the agenda. This is consistent with the spirit of the Bagley-Keene Act, as well as the practice of other state boards. We note that there was broad public comment at several points.

Third, as provided in some sections of the enabling statute, it would be helpful to the Board and the OHCA staff if potential actions are discussed at one or more meetings before taking action at subsequent meetings. This process allows the Board and the staff the opportunity to discover whether a proposed action is problematic or broadly acceptable. It may also bring to light implications or potential consequences that the Board or the staff have not considered but that the stakeholder community may bring to their attention. This approach was adopted by Covered California in 2011 and has served that state agency well.

Fourth, we also encourage the staff to post any written public comments subsequent to or in advance of a meeting so that the Board, stakeholders, and larger public may be informed of such comments.

Substance: Controlling Costs, Improving Affordability

Health Access offers a revised and extended version of our comments at the first meeting based on the discussion and presentation at that meeting.

- Consumers pay for increases in health care costs

Consumers pay directly for increases in health care costs by paying for premiums, share of premium, higher copays and skyrocketing deductibles. Consumers also pay for higher health care costs in terms of lower compensation, including not only wages and salaries but also reductions in other parts of compensation such as retirement contributions. Over the last twenty years, health insurance premiums have doubled and deductibles have increased even more quickly while wages have grown much more slowly and more slowly than inflation, more slowly than the state's gross domestic product. The amount that workers pay for their share of premium for individual coverage has doubled in the last twenty years.[1]

As recently as 2020, a majority of California workers had coverage without deductibles[2]. For too many, the deductible exceeds $1,000 a year and applies to all or almost all care[3]. Consumers call it "paying twice", once in share of premium and a second time for deductibles, copays and coinsurance.

- Every increase in health care costs worsens disparities related to the social determinants of health

Given the inherent regressivity of employer-sponsored insurance, higher health care costs worsen regressivity of coverage as well as inherently worsening disparities and income inequality. Today, a

[1] California Employers Health Benefits, 2021: Are Workers Covered? (chcf.org)
[2] California Employers Health Benefits, 2021: Are Workers Covered? (chcf.org) Slide 23
[3] California Employers Health Benefits, 2021: Are Workers Covered? (chcf.org)

family at 200% of federal poverty spends 40% of income on health insurance while an individual at 800% of poverty spends 8% of income on health insurance[4].

For the lowest income, spending 40% of income on ever higher health care costs mean food insecurity, housing instability, less money for utilities or transportation. For middle income consumers, it means higher copays and deductibles, more medical debt, a higher cost for share of premium—and less for other needs, whether it is the kids' college education or retirement security. For those who depend on Covered California, next year those who pick the standard silver plan will have a hospital deductible of $5,400 and $50 copays for primary care visits.

While some aspects of social determinants of health, such as race and ethnicity or sexual orientation and gender identity are not directly related to income, the lack of generational wealth and the high prevalence of medical debt in communities of color and for those in the LGBTQ community as well as continuing gender inequality in incomes cause disparities in the ability to afford care and coverage. An immigrant family supporting both children and seniors or a working mom working part-time to tend to elderly parents and teenagers or young children probably lacks the financial reserves to afford deductibles of $1,000 or $2,000 or more. Around a quarter of the population has $400 or less in liquid assets available[5]: an even higher percentage for Black and Latinx populations[6] has that little. This explains the other impacts of high health care cost sharing in terms of medical debt, credit card debt, and inability to afford other needs.

While the efforts of the Office of Health Care Affordability to contain health costs will benefit all Californians as well as our society and economy as a whole, the relief it provides will be more pronounced for low and moderate income workers and their families, including the many consumers living paycheck to paycheck.

- The United States, and California, have the most expensive health care systems in the world with some of the poorest health outcomes

From the most expensive health care system in the world, consumers get less care—fewer doctor visits, fewer days in the hospital, and worse outcomes. The presentation at the first Board meeting included a few examples of worse outcomes: there are many more. As the presentation also reflected, half of all Californians reported that they skip doctor visits, delay or fail to fill prescriptions

[4] Healthy CA for All November 17 Commission Meeting Slides: Slide 15: Emmanuel Saez and Gabriel Zucman, The Triumph of Injustice
[5] https://www.federalreserve.gov/econres/notes/feds-notes/assessing-families-liquid-savings-using-the-survey-of-consumer-finances-20181119.html#:~:text=Focusing%20on%20the%20first%20column%2C%20we%20estimate%20that,highest%20usual%20income%20quartile%20have%20at%20least%20%24400
[6] https://www.federalreserve.gov/econres/notes/feds-notes/disparities-in-wealth-by-race-and-ethnicity-in-the-2019-survey-of-consumer-finances-20200928.html

and suffer more medical debt due to costs. Lower income Californians face even greater cost challenges. The cost crisis prevents too many Californians from getting timely, necessary care.

Yet, in California, some hospitals get paid as much as 400% or more of Medicare—and charge an even higher sticker price. The hospitals that get the highest commercial payments tend to provide the least care to those on Medi-Cal and other low-income Californians.

Part Three: Spending Targets: Economic Indicators and Consumer Ability to Pay

- Spending targets should be based on the ability of consumers to pay for both care and coverage, particularly those at or below California median income

As the Health Care Affordability Board contemplates setting spending targets, the indicators on which the target is based, and monitoring compliance with targets, the target should be based on the ability of consumers to afford both care and coverage:

- Ability to afford care means out of pocket cost sharing, including deductibles, copays, coinsurance, maximum out of pocket costs and other cost sharing.
- Ability to afford coverage means the premium paid by the individual consumer or share of premium paid by the employee for individual and family coverage.

Both matter—and both have worsened dramatically over the last several decades.

Covered California is about to approve for 2024 a hospital deductible of $5,400 and a drug deductible for brand name and specialty drugs of $150 for the standard silver coverage[7]. Bronze coverage will provide three doctor visits at $60 per visit with a deductible of $6,300 for almost all other care. Reporting to DMHC indicates that 75% of those in the individual market both on and off exchange have coverage with an actuarial value comparable to either silver or bronze coverage[8]. None of us would defend such coverage as affordable in terms of the ability to obtain necessary care in a timely manner.

The maximum out of pocket limit has skyrocketed from $6,000 in 2014 to almost $9,500 in 2024 for individual coverage and almost $19,000 for family coverage[9]. A maximum out of pocket of almost $19,000 for family coverage literally means that for a family living at the median household income of about $84,000[10], the maximum out of pocket cost is over 20% of their gross income. For the half of Californians living on less than $84,000 a year, the maximum out of pocket is far more than 20% of income. And that is on top of the share of premium that employers require.

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[7] 2024 Proposed Plan Designs_Side-by-Side View_Board_PROPOSED v3 20230309.xlsx (coveredca.com)
[8] DMHC AB2118 report
[9] PowerPoint Presentation (coveredca.com) Slide 24
[10] U.S. Census Bureau QuickFacts: California

Is it any wonder that half of Californians report skipping or delaying needed care? Or that it is worse for lower income Californians?

- Consumer Affordability: California-Specific Measures

We have attached as an appendix a preliminary list of California-specific measures of affordability of both care and coverage as well as the impacts of the lack of affordable coverage, which range from medical debt to the small employers not offering coverage—or workers not taking up coverage because of lack of affordability. While the enabling statute does not require the Office or the Board to set consumer affordability targets, it does require the Board and the Office to consider the impacts of the spending targets on the ability of consumers to afford care and coverage.

There is no single measure that captures the lack of affordability and its impacts. For example, it is not sufficient to track deductibles alone if the share of premium skyrockets or more small employers drop coverage. But it is also easy to tell whether we are going in the right direction or in the wrong direction, as we have for decades.

We also recognize that the various measures vary in quality, duration and consistency over time. We look forward to a lively discussion about the perils of survey data as well as the other inadequacies of various measures.

Other states, including Massachusetts, failed to track consumer affordability impacts from day one, though they have since attempted to remedy this oversight. The California law is clear in requiring that consumer affordability is a primary goal of this state's effort and it creates a specific mechanism to achieve that.

We recommend that the Board and Office track multiple measures of consumer affordability for both care and coverage as well as impacts due to lack of affordability. While setting precise metrics may be premature, directionally the goal is clear: the lack of affordability of both care and coverage should stop getting worse and eventually improve. For each measure listed in the appendix, we know which way the arrow has pointed in the last several decades and the direction it should point in the future. As the conversation develops, we will offer more specific recommendations.

- GDP, Inflation not related to ability to afford care and coverage

Whether it is inflation, state gross domestic product or investment losses of the health care industry, none of these reflect the ability of low and moderate income Californians to afford health care or the other necessities of life—housing, food, utilities, transportation, much less retirement and the kids' college education.

California's economic growth, whether measured as state gross domestic product or another measure of general economic growth, is driven in large part by very wealthy industries such as entertainment, tech and biotech. The boom and bust of industries that helps to drive revenues in California's state budget also drives growth in the state domestic product. Such general measures of economic growth are not linked to the ability of families to afford care or coverage.

Similarly, general inflation only worsens the ability of families to afford care and coverage. Health care spending has grown more quickly than general inflation since 2000[11]. Only in the immediate aftermath of the pandemic has inflation in goods and services exceeded the growth of health care spending.

Recent research suggests that some of the financial challenges that appear to face the health care industry reflect shortfalls in investment income as a result of the downturn on Wall Street. As the authors of that piece ask,

> Wall Street losses should not impact private payers' and taxpayers' payments to hospitals. Asking these constituents to foot the bill for hospitals' investment losses not only lacks justification but will insulate hospitals from the consequences of their investment decisions.[12]?

The wealth of the health care industry is not an appropriate economic indicator on which to base spending targets.

We recommend that the economic indicator be based on median wages or median household income rather than indicators based on state gross domestic product, inflation or the wealth of the health care industry since wages or household income reflect the ability of consumers to pay for care and coverage. We also recommend use of the median rather than the average because of California's income inequality, which is more extreme than in many other states. We will offer further specific comments as the conversation develops.

Part Four: California is Different: Resources, Law and Specifics

Much of the presentation focused on the experience and discussions in other states, especially in Massachusetts. While it may be helpful to learn lessons from other states, such comparative work should always be put in the context of how different California is, in size, scope, and structure. It is not just that California is substantially bigger or exponentially more diverse. The very makeup of the health care market in California is different, from our early and greater reliance on managed care, to the range of public, nonprofit, and for-profit providers, to the extremes of wealth and poverty that they serve. We expect and welcome additional information about what is going on in other states—

[11] How does medical inflation compare to inflation in the rest of the economy? - Peterson-KFF Health System Tracker
[12] What's Behind Losses At Large Nonprofit Health Systems? | Health Affairs

in fact, we confer with our consumer advocates colleagues in these other states often—but we can and should also always check to see how their policy issues or policy approaches may play out differently in California.

In addition to the sheer scale of California, the complexity of the delivery system, and the diversity of our population, California also has a longstanding tradition of laws that are more consumer-friendly than required by federal law and a wealth of California-specific data and research that can provide an understanding of the California market grounded in California as well as enriched by observations from other states. Like the enabling statute for the Office itself, the implementation of the Office should learn from the experience of other states but not be bound by it.

This section of our comments will be an ongoing section with comments specific to topics or information presented to the Health Care Affordability Board. For that reason, this is not intended to be an exhaustive list of resources or relevant state laws.

Since most of those engaged in this effort have long focused on California, just a few examples to illustrate this point:

- Los Angeles County has a population of over 10 million, larger than the seven million people in Massachusetts—and a health system comparably larger.
- Of the 58 California counties, ten have a population larger than that of Rhode Island which has only a million people—and at least one (San Bernardino) has a geographic scale larger than the entire state of Rhode Island.
- Riverside and San Bernardino Counties have a population roughly equal to that of Oregon and a similar divide between the urban western end of those counties and the expanses of desert to the east.
- California has more than 400 hospitals: none of the other states with cost benchmarking commissions come close to the scale, complexity or diversity of California's health care system.

- Employer Coverage: California is different

Unusual among states, in California, 75% of employer coverage in California, including most large group coverage, is state regulated, primarily by the Department of Managed Health Care. DMHC regulates coverage for 7.8-9 million lives in large group, out of an estimated 8-9.5 million lives in state-regulated large group. Even more unusual among states, California provides considerable oversight of rates in the large group market[13].

[13] Large Group Aggregate Rate and Precription Costs for 2022 (ca.gov)

1127 11th Street | Suite 925 | Sacramento, CA 95814

Small group coverage is defined in California law as coverage purchased by small employers as having a threshold of 100 lives. California law also imposes very strict requirements on stop loss coverage sold to small employers which has had the functional effect of eliminating self-insured coverage for the small group market. About 2.3 million Californians obtain coverage from a small employer[14].

The law governing the Office of Health Care Affordability, and the board, was also designed to reach everyone, including the 5.5-5.6 million California consumers with self-insured large group coverage[15].

Conclusion

The ability of consumers to afford care and coverage was the crisis that drove the creation of the Office of Health Care Affordability. From Day One, the Health Care Affordability Board and the Office must be grounded in the unaffordability of the most expensive health care system in the world, and the experience of California consumers. The target for health care spending should be grounded in the ability of consumers, and other purchasers, to afford care and coverage, including both the direct and indirect impacts.

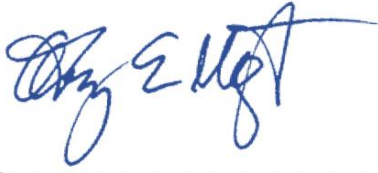
Growing health care costs will continue to worsen disparities, income inequality and other social determinants of health without necessarily improving quality or outcomes. The wealth of the California economy does not translate into the ability of consumers to afford health care, and inflation only worsens the problem for consumers. California's size and scale poses challenges for this effort, but we also have specific data and resources to make progress.

We look forward to working with you to transform the health care system in California through setting spending targets grounded in consumer affordability with the triple aim of lower costs, better outcomes and improved equity.

For more information or to answer any questions, please feel free to contact myself at awright@health-access.org or my colleagues Beth Capell at bcapell@jps.net. Thank you for your consideration.

Sincerely,

[14] 2022 Edition — California Health Insurance Enrollment (chcf.org), 2023 Projecting 2024 Estimates of Sources.pdf (chbrp.org)
[15] 2022 Edition — California Health Insurance Enrollment (chcf.org), 2023 Projecting 2024 Estimates of Sources.pdf (chbrp.org)



Anthony Wright
Executive Director

cc:

Elizabeth Landsberg, Director, Department of Health Care Access and Information
Vishaal Pegany, Deputy Director, HCAI, Office of Health Care Affordability
Members of the Health Care Affordability Board

Dr. David M. Carlisle, MD, PhD
Dr. Sandra Hernandez
Dr. Richard Kronick
Ian Lewis
Elizabeth Mitchell
Donald Moulds, PhD
Dr. Richard Pan

Assemblymember Dr. Jim Wood, Chair, Assembly Health Committee
Senator Susan Talamantes Eggman, Chair, Senate Health Committee
Assemblymember Dr. Joaquin Arambula, Chair, Assembly Budget Subcommittee on Health
Senator Caroline Menjivar, Chair, Senate Budget Subcommittee on Health

Appendix One:

Health Access Principles for the Office of Health Care Affordability

Health Access, the statewide health care consumer advocacy coalition, urges that the Office of Health Care Affordability seek to do the following:

1) SLOW UNCHECKED HEALTH CARE COST GROWTH TO BENEFIT CALIFORNIANS AND CALIFORNIA AS A WHOLE

- Set a cost growth benchmark that meaningfully reduces the rate of growth—because we will never meet a goal we don't set. Health care costs have gone unchecked for decades, based on the market power of a constantly consolidating industry.
- Limit health care costs so uncontrolled growth no longer worsens Californians' ability to afford the necessities of life or flattens the growth of wages which negatively impact consumers, workers, employers, the economy, government budgets, and society in general.
- Prevent further worsening income inequality and income-related social determinants of health, including housing instability, food insecurity, and the ability to afford education and retirement. Allow for further investment in public health and social services towards a sustainable health system.

2) PROVIDE REAL RELIEF TO CONSUMERS FROM EVER-INCREASING HEALTH COSTS

- Ensure consumers experience real cost relief. Slowing health care cost growth should be reflected in lower rate of growth in insurance premiums, deductibles, copays and other cost-sharing paid by consumers and other purchasers as well as improvements in compensation across the wage scale.
- Keep the focus on the financial barriers to care and coverage that cause patients to delay or skip care they need. Have patient and purchaser costs serve as the baseline for metrics that the Office uses to measure success. Past health reforms have introduced efficiencies and corrected market failures, but the savings too often do not make it back past the many middlemen and profit-takers.

3) ADVANCE HEALTH EQUITY TO SERVE CALIFORNIA'S VALUES AND THE SPECIFIC NEEDS OF OUR DIVERSE COMMUNITIES

- Ensure equity is incorporated into its design from inception. This includes collecting disaggregated data reflecting the full diversity of California and ensuring that goals and incentives support the care of those traditionally underserved.
- Take into account in all decisions that specific communities have specific needs. The Office was developed to have flexibility to make accommodations given the scale and diversity of our state.
- Recognize that the cost burden of our health system is uneven and is often regressive. Take pro-active steps toward a more progressive system.
- Design interventions that reduce, rather than exacerbate, health disparities while not using equity as an excuse to let the industry remain unaccountable for making improvements for our most vulnerable.
- Acknowledge the impact of higher health spending on income-related social determinants of health as well as the impacts of lesser public investments from housing to food to parks and built infrastructure.

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4) PRIORITIZE ONGOING IMPROVEMENTS IN QUALITY, ACCESS, AND EQUITY ALONGSIDE COST

- Ensure that reductions in cost growth do not come from reduced quality, cuts in access or services, or increased health disparities, but an actual improvement in value for our health care dollar.
- Work in lockstep with the other state agencies that can use their power as purchasers or regulators to share information and engage in coordinated efforts to improve access, quality, and equity.

5) TRANSFORM OUR HEALTH SYSTEM TO DISRUPT MISALIGNED PAYMENT INCENTIVES THAT WORK AGAINST IMPROVING HEALTH AND LOWERING COSTS

- Identify and work to reduce the huge and unnecessary price variations for health services, and other perverse incentives for providers to get bigger rather than better.
- Move from a system with wide payment disparities and misaligned incentives toward a system where the financial rewards come from improved quality, equity, and outcomes.
- Seek to use the Office's unique authority not just to lower costs but transform the health system to one that actually provides the right care at the right time at the right place.

6) PROVIDE THE PUBLIC AND POLICYMAKERS WITH AN "ALL IN" COMPREHENSIVE VIEW OF OUR HEALTH SYSTEM

- Advance a holistic understanding of the health system, rather than the blind spots that come from looking at just one sector or one aspect of costs or quality at a time.
- Provide a full view of the health system so policymakers are better equipped in public health emergencies to assess the state's health system as a whole.
- Include all parts of the health system, and not allow broad exemptions. While a focus on high-cost outliers is important, the Office should not ignore situations where a whole sector or region is charging inflated rates— such as when a competitor shadow prices a high-cost trendsetter.

7) TRACK TRENDS AND ENSURE TRANSPARENCY TRANSLATES TO ACTION

- Monitor the evolution of the health system, to identify, respond to, and even pro-actively prevent market failures, cost drivers, and other issues.
- Develop useful tracking mechanisms and reports so transparency translates into action, by the Office, other agencies, purchasers, policymakers, and the industry itself.
- Provide key analysis about mergers in order to provide direct and meaningful assistance to other agencies, like the Department of Justice, the Department of Managed Health Care, or other key health regulators and purchasers that can make the appropriate interventions.

8) OFFER TOOLS FOR TRANSFORMATION TO HELP THE HEALTH INDUSTRY MEET THE GOALS OF CONTAINING COSTS WHILE IMPROVING VALUE AND EQUITY

- Provide tools to the industry to meet its goals, including comparative data, providing positive models and strategies on alternative payment systems, primary care and behavioral health, workforce stability, and more, to help transform care to achieve the triple aim of improved outcomes, reduced disparities and slower cost growth.

- Provide tools for policymakers to facilitate shifts to a more standardized, unified, and universal health system to benefit all Californians.

9) CREATE MEANINGFUL ACCOUNTABILITY FOR HEALTH CARE AFFORDABILITY THROUGH PROGRESSIVE ENFORCEMENT, INCLUDING COMMENSURATE AND ESCALATING PENALTIES

- Demonstrate an unwavering commitment to health system oversight and enforcement, including penalties commensurate with the amount charged over the cost target and escalating for failures to meet the target.
- Showing seriousness about using the authority to impose penalties, to ensure accountability, and to allow the effects of this effort to come long before its first penalties.
- Use progressive enforcement to provide the opportunity for the health care industry, including specific entities, systems, and sectors to come into compliance with the targets.

10) CENTER CALIFORNIA CONSUMERS' EXPERIENCE AND VOICE IN ALL DELIBERATIONS AND DECISIONS

- Ground the Board, Advisory Committee, and Office deliberations in the impact health care cost growth is having on all Californians, including by developing guiding principles for its decision-making, and institutionalizing its consumer focus.
- Elevate consumer health care spending and affordability data in program design deliberations.
- Develop systems for ongoing engagement with the California public, specific communities, and those with lived experiences dealing with our health system. This includes regularly inviting consumer and consumer advocate testimony on key program design decisions.
- Have a public-facing website and materials, that describe how unconstrained cost growth prevent consumers from seeking timely access to necessary care, delaying doctor visits, filling prescriptions and other basic access to care, which hits hardest those with low and moderate incomes but affects all Californians.
- Ensure the Office explains its work in terms of the consumer's experience, engage in broad community outreach, and actively facilitate feedback from the public.

Appendix: Preliminary List:

Consumer Affordability: Measures and California-specific Data Sources

Market size: California

- Individual on and off-exchange: 2.5 million
- Small group on and off-exchange: 2.3 million
- Large group: state regulated: 9.5 million
- Large group: self-insured: 5.5 million

Cost of Care Measures: California-specific, California data sources

- Actuarial value:
  - Individual market: 25% of 80%-90% AV
  - Small group: 64% at 80%-90% AV
  - Large group, state regulated: 73% over 90% AV
  - Sources: DMHC rate review
- Deductibles:
  - Individual: zero deductibles: 15% on-exchange (DMHC rate review)
  - Small group: zero deductibles: 25% (DMHC rate review)
  - Large group: zero deductibles: 47% (CHCF Employer coverage)
- Maximum out of pocket limit:
  - For 2024, $9,450 for an individual and $18,900 for family
- Primary care copays by market segment: available from Covered California, DMHC rate review, CHCF employer coverage survey

Cost of Coverage: Premiums/Share of Premiums, Employer Offer, Worker Take-Up

- Share of premium: data sources vary by market segment:
  - Individual market: ACA/ARP
  - Group market: CHCF employer survey
- Employer offer of coverage, worker take-up of employer coverage: data sources: CHIS and CHCF employer survey

Impacts of Lack of Affordability:

- Skipped, delayed care
- Medical debt
- Credit card debt
- Unable to afford other necessities
- Sources: California Health Information Survey, CHCF surveys individual consumers

Data Sources: Preliminary list of California-specific data sources:

CHCF employer surveys, CHCF opinion surveys

- California Employers Health Benefits, 2021: Are Workers Covered? (chcf.org)
- Weighed Down: Californians and the Financial Burden of Health Care Coverage - California Health Care Foundation (chcf.org)
- The 2023 CHCF California Health Policy Survey

- Affordability on California's Individual Market: What Policymakers Need to Know (chcf.org) 2019

DMHC rate review reports:

- Large Group Aggregate Rate and Precription Costs for 2022 (ca.gov)
- AB2118 Report Individual and Small Group Report MY 2022 (ca.gov)

Individual market: Covered California enrollment data by income

- California's Health Benefit Exchange

California Health Interview Survey: 20,000 person annual survey

- CHIS 2022 Questionnaire Topics (Source).pdf (ucla.edu)
- About CHIS | UCLA Center for Health Policy Research

Medical Expenditure Panel Survey (MEPS): average deductibles, share of premium, more by state: MEPS-IC Data Tools | AHRQ Data Tools