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Health Care Affordability Board
September 19, 2023
Public Comment

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

Date	Name	Written Comment
10/06/2023	Jennifer Robles on behalf of Health Access CA	See attachment #1.
10/10/2023	Anete Millers on behalf of California Association of Health Plans	See attachment #2. We appreciate the Board's consideration of the policy principles highlighted in this letter as OHCA continues its important work analyzing health care cost drivers and developing spending targets.
10/18/2023	Ben Johnson on behalf of California Hospital Association	See attachment #3.

HEALTH ACCESS CALIFORNIA

October 6, 2023

Mark Ghaly, M.D., Chair
Health Care Affordability Board
Secretary, California Health and Human Services Agency

Elizabeth Landsberg, Director
Department of Health Care Access and Information

Vishaal Pegany, Deputy Director
Office of Health Care Affordability

2020 W. El Camino
Sacramento, CA

CC: Megan Brubaker, HCAI

Re: September 19, 2023, and October 24, 2023 Board Meetings

Dear Dr. Ghaly, Ms. Landsberg, and Mr. Pegany,

Health Access, the statewide health care consumer advocacy coalition committed to quality, affordable health care for all Californians, offers comments and recommendations on the following:

- Risk Adjustment
- Economic indicators on which to base the spending target
  - Consumer Lack of Ability to Afford Care and Coverage
  - Historic versus Projected
- Population adjustments: Aging
- Adjustments to the spending target
- Market review:
  - Monterey
  - Attorney General Oversight

<u>Risk Adjustment</u>

The Advisory Committee and the Affordability Board revisited the discussion on clinical risk adjustment at each of their last meetings. At the June Advisory Committee meeting, many Advisory Committee members agreed with the direction to limit risk adjustment to age and sex, as recommended by staff based on the experience in other states. At the September meeting, a few Advisory Committee members strongly supported risk adjustment based on clinical status. These Committee

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members represent provider entities which control the clinical data used for risk adjustment. Concerns about clinical risk adjustment reflect the experience in other states where such measures have been gamed or overused to undermine accountability for the spending target.

As discussed at both the Advisory Committee and the Board meeting, and as previously presented by staff, including clinical risk adjustment may be contrary to the goal of advancing health equity. Those who are low or moderate income or from communities of color tend to have less access to care and consequently their providers and health systems have less data on their health and thus lower risk scores. The lower risk scores reflect not less need but less access to care.

Health Access would support greater consideration for those serving low-income populations and lower targets for those serving the affluent who have better access to care. If a provider such as a medical group or hospital system serves a population with high needs such as a disproportionate number of persons with disabilities (as documented for other programs such as Medi-Cal, Medicare, CCS, or Regional Centers), this fact can be raised in the context of progressive enforcement.

Health Access recommends: Either no risk adjustment or risk adjustment based on age and sex. Risk adjustment based on clinical status should not be considered in determining compliance with the spending target if the clinical factors are documented by those entities that benefit from higher clinical risk scores.

Economic Indicators as the Basis for the Spending Target: Consumer Affordability

As a recent study asks, "What Can We Afford?[1]"

Both the Affordability Board members and the Advisory Committee overwhelmingly supported the use of wages or household income as the best measure of what consumers can afford. Health Access agrees. We also agree that either "median" wages or household income is most appropriate, particularly in a state with grave income inequality such as California. "Average" wage or income would artificially exaggerate what Californians can afford because of the small fraction of very high- income earners: for example, there are 109,000 tax filers who earned over $1 million in income in 2020[2]. Conversely, a substantial share of Californians earns so little that they are exempted from state personal income tax.

Some areas of California are far more prosperous than others and the distribution of economic prosperity and downturns change over the decades. Some data is available at

[1] What can we afford? Considerations for aligning Office of Health Care Affordability spending target with Californians' ability to afford increases - UC Berkeley Labor Center
[2] Mental Health Services Act: Revenue Volatility and the Governor's Proposal to Reduce Allowable County Reserves (ca.gov)

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the county or substate level: this includes wages and income but not state gross domestic product or potential gross state product.[3] The availability of data at the county or substate level also argues for the use of wages or income rather than state GDP or potential gross state product.

"Potential gross domestic product" refers to an estimate of the value produced by the economy if labor and capital had been employed at their maximum sustainable rate. This measure assumes steady growth and stable inflation.[4] This theoretical concept is based on assumptions that do not exist in the real world: steady growth and stable inflation as well as the employment of both labor and capital at its maximum sustainable rate. "Potential gross state product" is not an "established measure" in California since it is not routinely collected and published by either the Department of Finance or the Legislative Analyst Office. It is also not available at the county or regional level. Since it was adopted in Massachusetts a decade ago, several states that followed Massachusetts replicated this measure. Other states heavily weighted measures of wages or household income, usually as the predominant benchmark. California can learn from other states, including not replicating that which does not make sense. To us, PGSP does not make sense as an indicator.

When asking "What Can We Afford?", the regressivity of employer-sponsored health insurance should be uppermost in the minds of policymakers. Employer-sponsored health insurance is regressively financed: for those with below-median income and even those in upper-middle income quartile, the employer share of premium along with the worker share and cost sharing such as deductibles and copays eat up a substantial share of compensation[5]. The impact of a $5,000 deductible is very different for each income quartile: even for those in the upper middle quartile, $5,000 is a significant financial hit. For those below median, such an amount destabilizes a family's finances and fortunes.

Health Access recommends:

1. Use of median wages or median household income as the exclusive or dominant economic indicator on which to base the spending target.
2. No use of "averages" for either wages or income because of the extreme income inequality in California,
3. Not using state GDP or "potential gross state product" because neither is related to the ability of consumers and working families to afford care and coverage.

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[3] What can we afford? Considerations for aligning Office of Health Care Affordability spending target with Californians' ability to afford increases - UC Berkeley Labor Center

[4] What is potential GDP, and why is it so controversial right now? | Brookings

[5] The Forgotten Middle: Worsening Health And Economic Trends Extend To Americans With Modest Resources Nearing Retirement | Health Affairs This study provides a striking illustration of the disparities in resources between these income levels and those in the upper quartile: the average annual financial resources (pre-tax/pre-transfer) for each quartile are lower $1,281, lower-middle $31,737, upper middle $90,222, and upper $306,981 in 2018

4. A focus on affordability for those with below-median incomes and those in the upper middle quartile of the income scale.

Indicators: Historic vs. Projected?

A discussion that the Board and Advisory Committee have yet to have is whether indicators should be historic or projected. Other states have varied in their choices. This choice has implications with respect to what indicators are available and at what level. For example, projected indicators may not be available at the regional level and projected wages are apparently available only as "average" wage, not "median" wage when in our view, "median" is a better approach than "average".

Projecting the future is hard. Predictions of future spending, including on health care, are notoriously prone to error. For example, in March 2023, the Congressional Budget Office published an analysis of its projections of federal health spending for the prior decade. This analysis found that the projections made at the time of the enactment of the ACA failed to predict a significant slow-down in health care spending that has occurred in the decade since 2010[6] when the ACA was enacted. This slowdown in spending, totaled $1.1 trillion dollars between 2010 and 2020, just for Medicare and the federal share of Medicaid[7]. This slowdown occurred despite the massive expansion of eligibility for Medicaid in 2014. To quote CBO,

> Most of the overestimate for the Medicare and Medicaid programs stemmed from an overestimate of spending per beneficiary, not an overestimate of the number of beneficiaries. Less-than-anticipated spending for prescription drugs in Medicare Part D and for long-term services and supports (LTSS) were two significant sources of error in CBO's 2010 projections[8].

While predicting future spending is hard and subject to error, a review of historic data for measures such as median wage, median income and state gross domestic product indicates significant volatility. Some of this volatility can be addressed through averaging three to five years together or even a longer period.

As the CBO analysis of its own projections suggests, change does happen in health care. While outliers and bumps like the introduction of a high-cost drug like Sovaldi or a global

[6] CBO's Projections of Federal Health Care Spending March 23, 2023 to Sen. Sheldon Whitehouse, Chair, Senate Budget Committee

[7] The overestimate was literally double the $900 billion set aside in 2010 for the ACA expansions of coverage. What a difference it would have made for consumers in the individual market to have had those dollars spent on lower premiums, lower deductibles, and lower copays as well as subsidies farther up the income ladder to the upper middle quartile.

[8] CBO's Projections of Federal Health Care Spending March 23, 2023 to Sen. Sheldon Whitehouse, Chair, Senate Budget Committee

pandemic may be addressed through post-hoc adjustments, some of this needs to be addressed by ongoing monitoring and policy analysis of the impacts of spending targets.

Happily, CBO found that for 2010-2020, spending on patients with cardiovascular diseases declined due to better management of conditions such as hypertension and diabetes. This speaks to the triple aim mission of the Office to reduce costs while improving outcomes and equity through better management of care. It is both possible and essential to do so. In the future, if some of the reforms contemplated in the OHCA statute lower costs, then it may be possible to further reduce overall spending growth.

Health Access looks forward to further discussion on this topic.

Spending Targets: Population Indicators: Aging

Health Access question whether the usually slow and largely predictable ebb and flow of a population's age should be included as the basis for a spending target. Is adjusting the spending target for age and sex sufficient so that using aging as a population indicator is duplicative? Costs of the aging population tend to be largely for those over age 65, when most of the cost is borne by the Medicare program. We also note that CBO found that between 2010 and 2020, the rate of growth in Long Term Services and Supports slowed significantly: this has been germane to the discussion about the impact of aging on the spending targets. Prior to 2010, LTSS grew at the rate of 5% annually but it declined to 1% for 2010-2020.

LTSS is not a significant consideration for commercial insurance. Spending on long term care by commercial coverage is infinitesimal. For commercial coverage where cost growth is most problematic, the impact of aging is far less significant.

We were surprised that no other state uses population indicators as a basis for spending targets. We look forward to further discussion of this topic.

Health Access recommends: Not using age as a population indicator to adjust the spending target.

Spending Targets and Equity and Quality Measures

The enabling statute for the Office requires the Office to measure equity and quality as well as spending. Fortunately, several state agencies are already working on equity and quality measures. Covered California, Medi-Cal and CalPERS all collect and publish quality measures for their respective contracting health plans and have done so for many years now. Covered California did a five-year review in 2019 that was very instructive[9]. Medi-Cal

[9] Covered California Holding Health Plans Accountable for Quality and Delivery System Reform

similarly looked at the failure to improve quality by its contracting plans when it redid all of the Medi-Cal managed care contracts in recent years.

The Department of Managed Health Care published its report on Equity and Quality Measures late in 2022: 2022 Health Equity and Quality Committee Recommendations Report (ca.gov). This will lead to regulatory standards to for DMHC-regulated health plans, with possible fines for failure to improve equity and quality. This regulatory approach which locks in specific thresholds has implications quite different than the iterative approach of a contracting agency such as CalPERS or Covered California. While the statute does not require OHCA to establish quality measures until 2026, there is a solid foundation of state-level information about quality measures for OHCA to draw on today.

Health Access Recommends: Consideration of equity and quality measures adopted by other state agencies, taking into account the differences among those agencies in terms of populations served and approaches.

Adjustments to the Spending Target

As the presentation to the September 2023 Board meeting acknowledges, the law requires the Office and the Board to "review potential factors to adjust future cost targets".[10] But the law does not require the Office or the Board to adopt such adjustments either to the statewide target or sector targets, only to consider them The Office and the Board may adopt some or none of the "including but not limited to" list of possible adjustments: both the Office and the Board are only required to review the list of possible adjustments.

We offer preliminary comments on possible adjustments. In future letters, we intend to offer additional comments about standards and process for adjustments.

In other states, events such as the introduction of Sovaldi and a global pandemic resulted in adjustments. While these examples certainly deserved consideration, others do not.

Health Access would oppose adjustments to account for state mandates that have been in place for decades. Examples include hospital nurse ratios and seismic requirements. The requirement for hospital nurse ratios has been in place for almost twenty years and is not a new mandate. The requirement that hospitals be operational after an earthquake was enacted in 1994 as a compromise and a concession to the hospital industry which opposed immediate imposition of this requirement.[11] Hospitals have known for thirty years that they

[10] Health and Safety Code 127502 (d) (4)
[11] The requirement for the year 2020 was that a hospital building not collapse during an earthquake. Unfortunately, that low standard could still result in the evacuation of as many as one out of four hospital buildings affected by an earthquake, just at the moment when emergency services are bringing patients to the hospital.

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would be required to comply with this standard and a majority of hospital buildings now meet this higher standard.

Health Access would oppose adjustments for costs that providers should address through better management of care and costs. The theory behind OHCA is that the health system, and its elements, can reduce costs while improving equity and outcomes. For example, better management of ambulatory sensitive conditions has been known since before the creation of OSHPD as a major opportunity for cost control while improving outcomes and equity and yet, too many health systems still fail to do so forty years later. Reducing readmissions falls into the same bucket of controllable costs through better management of care. Health systems could help to control the cost of pharmaceuticals and devices by refusing admission to "detailers" or salespersons for pharmaceutical or device manufacturers, prohibiting gifts from these manufacturers to prescribers, and paying administering health professionals a flat fee rather than a percentage of the cost. Each of these steps have been taken some systems and should be adopted by all. Whenever an adjustment is proposed, OHCA should consider whether better management could result in lower costs and improved outcomes. OHCA should not simply accept assertions that cost inputs are beyond the control of those elements of the health care industry asserting the impact of the cost input. The question should always be: how can the provider of care do a better job of managing costs and improving outcomes?

Health Access also recognizes that new mandates may be adopted or other costs may be, temporarily, beyond the control of an element of the industry. Fortunately, because the spending targets are not subject to the regulatory process, such determinations can be made at a future date as circumstances require.

Health Access Recommends:

1. No adjustments for long-standing state mandates such as hospital seismic and nurse ratios.
2. No or limited adjustments for costs that providers could control but fail to take common-sense steps to better manage care, such as reducing all-cause readmissions or emergency room visits and hospitalizations for ambulatory sensitive conditions.
3. Future consideration of short-term perturbations or rare events beyond control or predicting such as a global pandemic or the introduction of a high cost, sole-source drug like Sovaldi.

<u>Market Review: Monterey</u>

At every meeting of the Board, working families from Monterey and their representatives have made a compelling case about the lack of affordability of health care being even worse in Monterey than in other parts of California. We look forward to future discussions

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about "sector" targets such as regions and health systems but for now, the case of Monterey calls out for action.

Health Access recommends: OHCA use its statutory authority to conduct a market failure study of Monterey with consideration of setting a regional target for that area that is lower than the statewide target and doing so prior to 2028, as allowed by the law.

Market Review: Attorney General Oversight of Non-Profit Health Facility Mergers

For the last thirty years, the California Attorney General has reviewed and consented to mergers involving non-profit health facilities. More than 90% of these mergers have been approved, usually with conditions such as requiring that the acquiring entity keep open the emergency room, labor and delivery and other important hospital services for the community[12]. Literally hundreds of transactions have moved forward over the last thirty years in California, with conditions that protect the services communities rely on while preventing price spikes as a result of transactions. Health Access was the sponsor of much of the legislation authorizing this authority and from time to time participates in this process[13].

In the specific instance of Madera Community Hospital, the conditions the Attorney General sought included keeping open the emergency room, emergency reproductive services, surgical care and other important hospital services[14]. The acquiring entity, Trinity, is a large multi-state chain that operates one other hospital in California, St. Agnes, nearby in Fresno[15]. Since the closure, at least two other suitors have emerged[16]. The Governor and Legislature also took action to assist the small number of truly distressed hospitals[17]: HCAI recently awarded $300 million in assistance, including for Madera. The management failures of the prior management of Madera Community Hospital should not impede the work of OHCA in reviewing transactions.

For more than twenty years, Attorneys General have contracted out health impact analyses because the need for such analyses waxes and wanes as merger activity ebbs and flows as interest rates change and market dynamics shift. Also, Attorneys General found that when the Department of Justice was the client, the reviews were more comprehensive and in-

[12] States' Merger Review Authority Is Associated With States Challenging Hospital Mergers, But Prices Continue To Increase | Health Affairs Fulton et al, Health Affairs, December, 2021.
[13] Merger Watch - Health Access (health-access.org) and AG-oversight-final.pdf (health-access.org), Capell, Health Access, 2022.
[14] Attorney General Bonta Conditionally Approves Sale of Madera Community Hospital to Trinity Health | State of California - Department of Justice - Office of the Attorney General
[15] Cross-Market Mergers - The Source on HealthCare Price and Competition
[16] **Jilted lover' or likely suitor? New firm wants to take over bankrupt California hospital,** August 30, 2023, Melissa Montalvo, Fresno Bee
[17] We note that some asserted that as many as 20% of California hospitals were in financial distress but a more careful review by HCAI found a far, far smaller number.

depth than the materials presented by the parties to the transaction. For example, in one early transaction in the 1990s, a hospital near downtown Los Angeles, Hollywood-Presbyterian, asserted that there was no need for charity care because there were no uninsured nearby, at a time when one in three Angelenos was uninsured. This assertion was so lacking in credibility that then Attorney General Dan Lungren, a Republican from Long Beach, commissioned one of the first health impact analyses done at the request of the Attorney General.

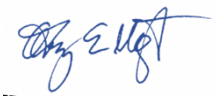
The Department should have the time and resources necessary to review what may in some instances be multi-billion-dollar transactions as well as the flexibility to move more quickly with small transactions or transactions involving legitimately distressed entities. The law allows HCAI to recover the reasonable costs of reviewing transactions and sufficient time to consider the implications of such transactions. For example, several representatives of private equity and providers that will be subject to the Market Impact Reviews suggested that fees should be capped at $75,000 or similar amounts and the time for review should be constrained significantly, either of which would severely limit the ability of the Office to review multi-billion-dollar transactions that took months or years to put together. Health Access would oppose handcuffing the Department by limiting either the fees or the time available for review.

Health Access recommends:

1. Recognition that over 90% of transactions reviewed by the Attorney General are approved, contrary to the impression left by some commenters.
2. CMIR reviews should place the facts in a broader market context than what may be presented by the parties to the transaction.
3. Sufficient resources and time to review multi-billion-dollar transactions as well as speedier review of small transactions and transactions involving truly distressed hospitals.

Health Access looks forward to the continued discussion on these important topics and more.

Sincerely,



Beth Capell, Ph.D.
Consultant

Anthony Wright
Executive Director

Cc: Assemblymember Wood, DDS, Chair, Assembly Health Committee

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Senator Eggman, LCSW, Chair, Senate Health Committee
Assemblymember Arambula, MD., Assembly Budget Subcommittee
Senator Menjivar, Senate Budget Subcommittee
Mary Watanbe, Director, Department of Managed Health Care

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October 10, 2023

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

Re: Office of Health Care Affordability Policy Considerations

Dear Secretary Ghaly and OHCA Board Members:

The California Association of Health Plans (CAHP) represents 44 public and private health care service plans (plans) that collectively provide coverage to over 28 million Californians.

Our members are pleased to see California placing such a high priority on affordability. This emphasis is certainly welcome, as policymakers often seem content to debate proposals that make health coverage more expensive or bureaucratic for consumers.

It is refreshing to have a real discussion about addressing the underlying cost drivers of health care. The vast majority of health plan spending in California goes to pay for medical services like hospital and doctor visits, prescription drugs, lab tests, x-ray, and medical supplies. As you will see in the attached fact sheet, hospital and drug costs account for a substantial part of the health care premium dollar, and prescription drug cost trends are increasing.

The Office of Health Care Affordability (OHCA) aims to take a comprehensive approach to addressing rising health care costs. While CAHP and its members support the approach, due consideration is needed to achieve the end goal of addressing health care affordability, quality, and equity in a holistic manner.

As we begin the challenging task ahead, including the development and measurement of Total of Health Care Expenditures (THCE), we ask that the OHCA Board carefully consider the issues below. We look forward to participating in constructive discussions to shape solutions that will deliver real patient choices, lower costs, and expand coverage to the remaining uninsured Californians who deserve affordable quality coverage.

OHCA Should Leverage Existing Data Reporting Requirements

California health plans are tightly regulated and must comply with extensive transparency requirements. Our members are overseen by, or otherwise accountable to, the Department of

Managed Health Care (DMHC), Department of Health Care Services (DHCS), Covered California, CalPERS, and the Department of Health Care Access and Information (HCAI).

Health plans currently file several reports on quality, alternative payment models, or other reports to the departments and entities listed above. All efforts should be made to avoid the unintended consequence of increasing administrative costs in health care. To that end, the OHCA Board should strongly consider using existing data submissions by health plans to these regulatory and oversight entities. As one example, OHCA can use the same definitions for non-claims data as HCAI so that reports by plans can be generated at one time and not needlessly replicated. At the same time, we recognize there may be gaps in the existing data submissions that impede a fully defined THCE. Thoughtful analysis should be conducted to determine where the gaps exist and how to best obtain the information, which leads to the following point.

OHCA Should Consider the Uniqueness of California's Health Care Landscape

CAHP and its members appreciate OHCA's dedication to strategic planning, including all the background research that has gone into analyzing THCE models in other states and applying key lessons learned to California's approach. However, there is one foundational element that we should not lose sight of throughout this process: simply put, California is unique. Therefore, while lessons from other states' program implementation can help inform OHCA's efforts in California, we must also carefully consider where, and why, California should be treated differently.

I. Models vs. Market Reality

Throughout the series of OHCA board meetings that have convened to date, Michael Bailit and his team at Bailit Health have done a terrific job of illustrating THCE programs and spending targets in other states, like Massachusetts and Oregon. From an educational perspective, these presentations have led to several fruitful discussions.

However, as we continue using examples from other states to refine California's approach, we urge the OHCA board to consider the realities of California's health care market to help fill in gaps which may not be addressed from a purely theoretical standpoint. While we understand that Massachusetts is an effective example of a state that has paved the way for THCE data collection and Alternative Payment Model (APM) adoption, there are stark differences between Massachusetts and California that will heavily impact how California navigates its own affordability program in practice:

- **Size** – At the outset, California has a population approximately 20 times the size of Massachusetts, with wide geographic, demographic, and economic variances. This is something that has been touched on during the OHCA board meetings, but we want to underscore the significance of this point. California's health care delivery system is enormous and complex, and as a result, the approach to measuring spending in this state is an enormous and complex undertaking as well.
- **Payment Arrangements** – California's health care market is comprised of a wide variety of payment models. In the commercial market, for example, providers are far more likely to be

paid via capitated arrangements with health plans, which limit the plans' ability to use those payments as a valid data source to measure spending. We hope OHCA will consider why, rather than forcing California into a model that works far better in a state like Massachusetts where you have little to no capitation, it would be more effective to look at data sources from a whole-market perspective (i.e., collecting from hospitals, providers, *and* plans).

- **Care Delivery and Provider Coordination** – California is a massive state, and thereby has an expansive provider network. OHCA's ability to accurately attribute individual members to primary care clinicians (and attribute clinicians to provider entities) will be challenging and convoluted in comparison to what can be done in other states. HMO and PPO product lines have very different value-based payment arrangements and utilization of care. By definition, they vary in how any given primary care provider may be directing a consumer's care. Even if the end goal is the same, OHCA should carefully consider how some strategies may differ across product types in the interim. We look forward to additional discussions about member attribution as OHCA contemplates how to capture capitation dollars and quantify total health care dollars spent.

Keeping an Eye on the Prize: Creating a System of Long-Term Sustainability

Our member health plans are working in good faith to help OHCA develop ways to measure THCE, adopt APMs, and establish spending growth targets. Health plans are grateful to be active participants in this important process, and through continued dialogue with OHCA's leadership, we believe that California will be well on the way to creating a sustainable health care system.

Through collaborative discussions with OHCA workgroups, health plans have had the opportunity to share valuable real-world insight about health care expenditures, contracting arrangements, data access and tracking, and opinions on methodology. These discussions have shed light on the wide variety of payment models and systemic complexities that exist in California's health care market, along with barriers and impossibilities that should be accounted for. We support OHCA's mission to promote affordable, value-based care, but as the Office continues its work on THCE and adopting the state's first spending target, we must bear in mind the objectives of OHCA's enacting statute and its focus on the underlying costs of care, leverage existing data, and take into account California's unique health care system.

Sincerely,

Charles Bacchi
President and CEO

Cc: Members of the Health Care Affordability Board

California Hospital Association

October 18, 2023

Mark Ghaly, MD
Chair, Health Care Affordability Board
1215 O St.
Sacramento, CA 95814

SUBJECT: Comments on the September 2023 OHCA Board and Advisory Committee Meetings

Dear Dr. Ghaly:

On behalf of our more than 400 hospital and health system members, the California Hospital Association (CHA) appreciates the opportunity to comment on the September 2023 proceedings of the Health Care Affordability Board and Advisory Committee. We share the Office of Health Care Affordability's (OHCA) commitment to improving the affordability of health care for all Californians. We are here to partner with OHCA to promote affordability while addressing longstanding deficiencies in access, quality, and equity.

This letter provides recommendations and considerations in four key areas in which OHCA and the board are currently making or preparing important decisions:

- **Market Oversight.** We thank OHCA for the positive changes included in the revised October 9, 2023, cost and market impact review (CMIR) regulations, in particular for clarifying that ordinary business transactions are not covered and establishing an expedited review process when access is threatened due to provider financial instability. However, we request a large number of additional amendments to sharpen the focus on the most impactful transactions, clarify and speed up review timelines, add reasonable protections around fees, ensure consideration of the benefits of transactions, clearly formulate the criteria for determining whether to conduct a full CMIR, reduce the burden of the regulations' information submission requirements, and protect confidentiality.
- **Spending Targets.** The September board and advisory committee meetings included valuable discussions of the potential design of the spending targets, but certain important perspectives were missing. Board and advisory committee members expressed potential interest in spending targets based on economic indicators such as growth in average wages. However, as we show below, in peer countries such as Australia, Canada, Sweden, and the United Kingdom, per capita health care expenditure growth has far outpaced average wage growth. These consistent trends among peer countries with diverse health care systems indicates that drivers other than health care policy – like population aging, labor market dynamics, and technological evolution– are behind the relatively high growth in health expenditures. Ultimately, this suggests that a target that is not reflective of the underlying drivers of health care cost growth, such as one solely based

on average wages, would result in severe underinvestment in California's health care system and seriously undermine access to quality care.

- **Risk Adjustment.** At the September board meeting, OHCA announced its intention to risk adjust health care entities' spending data only on the basis of age and sex, foregoing clinical risk-adjustment approaches that perform orders of magnitude better than age and sex in explaining variation in health care spending. We remain worried that this will penalize health care entities for treating high-risk patients, thereby exacerbating health inequities. We summarize research that shows the negative impacts failing to account for risk selection can have on vulnerable populations, in this case, Black infants. We recommend that OHCA instead perform both clinical and non-clinical adjustment during initial implementation to test which approach is better suited to achieving OHCA's objectives of promoting affordable, high-quality, and equitable care.
- **Patient Attribution.** We reiterate our request for early engagement with providers to ensure that the patient attribution methodology OHCA adopts is clearly prescribed via regulation, transparent, open to validation by providers, minimizes misattribution, and calibrated to cover only those providers that have a meaningful influence on their patients' utilization patterns and costs.

Market Oversight

Earlier this month, OHCA released revised draft regulations on the CMIR process. The revised version of the regulations contains meaningful positive changes, for which we thank OHCA. However, CHA has a number of significant remaining concerns with the CMIR regulations as currently drafted. We ask for a number of meaningful changes to ensure the regulations accord with OHCA's authorizing statute and prevent avoidable and widespread negative impacts on California's health care providers and their patients.

Further Focus on the Most Impactful Transactions. As drafted, the regulations establish noticing and materiality requirements that would capture a large number of market and operations activities that extend beyond what was intended by the authorizing legislation. We urge OHCA to make additional changes to narrow the draft regulations and focus its efforts on transactions likely to have significant effects on the health care market, reduce the uncertainty around when filing is required by health care entities, and ultimately lighten the burden placed on health care entities—including small and rural entities—seeking business and operational relationships to continue delivering accessible and high-quality care in their communities.

- **We Applaud the Exemption of Transactions in the Ordinary Course of Business.** The former version of the draft regulations would have required routine changes in business operations to go through the CMIR process. For example, basic activities like a hospital contracting with a health plan to be an in-network provider, updating an electronic medical record system, securing a loan, or leasing new medical office space would have been covered. The revised regulations by-and-large address this flaw by categorically exempting transactions in the usual and regular course of business from the definition of a transaction. We thank the office for this critically needed change. We ask OHCA to clarify that this exemption extends to "ordinary and customary *financing* transactions" to avoid notices relating to the ordinary financing of a providers' operations, such as taking out a loan to purchase a large piece of medical equipment or bond financing a capital improvement project.

  Conform to the Materiality Requirements in Statute. State statute requires a notice of a material change only when a health care entity transfers "*a material amount* of its assets to one or more entities" or transfers control, responsibility, or governance of "*a material amount* of the

assets or operations to one or more entities." In other words, each circumstance requiring a filing must include a threshold dollar amount of assets and/or a threshold measure of control *that is being transferred*. Several of the conditions requiring notice of a material change under the regulations fail to comply with this statutory imperative. They instead mention a dollar amount or percentage for a resulting revenue increase, resulting new revenue, or a new form of ownership. The regulations conflate a "material transfer" with "material resulting revenue." We recommend various amendments to conform the regulations to statute and ensure filings are required only when a material amount of assets or control is transferred.

- **Establish Reasonable Asset Transfer Materiality Thresholds Pegged to Inflation**. We maintain that the $25 million threshold for providing notice is much too low, neither recognizing the size of California nor the 30% inflation that has occurred since Massachusetts set the precedent for this threshold. To prevent ever smaller transactions (in real dollar terms) from falling under the review process, CHA recommends that any adopted threshold be updated regularly to account for inflation. To address both these concerns we recommend adopting the Federal Trade Commission benchmark. If OHCA does not adopt this benchmark, we recommend applying a standalone inflation adjustment to whatever dollar thresholds are adopted.
- **Conform With Generally Accepted Definition of "Control."** The draft regulations now define a change in control as a transaction that transfers more than 25% of the control of a health care entity. This threshold is still far too low. A person or corporation with a 25% interest in a health care entity does not control the health care entity. Moreover, the threshold belies substantial legal precedent as to the meaning of "control." Both the California Corporations Code and the Federal Trade Commission set a 50% threshold for defining control. As a rule of statutory construction, the Legislature is presumed to know existing law when enacting new laws. As such, they undoubtedly knew the definition of "control" and chose to use that term in the governing statute. We recommend the 50% threshold be adopted.

Establish Clear and Speedy Timelines for CMIR. We thank OHCA for proposing an expedited review process for transactions intended to save financially distressed providers and prevent losses in access. However, we remain concerned that the CMIR process would take a minimum of 250 days for transactions subject to full review—over two months longer than Oregon's comparable deadline. This would add hundreds of thousands of dollars to the cost of transactions and produce a chilling effect on prospective collaborations, regardless of how beneficial the arrangement would be to California patients and communities. We again urge OHCA to expedite and clarify its timelines for the CMIR process. Specifically, we request several practical changes to deadlines to reduce the timeline to 200 days—comparable to that in other states. We further ask OHCA to clarify OHCA's missing deadline for publishing preliminary reviews, establish reasonable protections against overly long and potentially unrestricted tolling against OHCA's deadlines, and adopt additional reasonable rules that hold OHCA accountable to achieving its deadlines.

Establish Reasonable Fees for CMIR Activities. Existing governmental reviews of arrangements among health care entities regularly entail hundreds of thousands of dollars in costs to reimburse government agencies for their use of outside consultants and experts. Because government agencies simply pass along these costs to regulated entities, the fees charged by consultants to government agencies often greatly exceed the amounts these same consultants charge directly to health care entities for similar work. For this reason, and to comply with statutory requirements, it is critical for OHCA to put in place reasonable protections regarding the fees that will be charged to health care entities under the CMIR process. We again ask OHCA to amend the regulations to ensure that fees charged are reasonable and accord with the economical costs of conducting a review.

Ensure Benefits of Proposed Transactions Are Given Appropriate Consideration. OHCA's authorizing statute requires that the benefits of proposed transactions be considered in the CMIR process. However, the revised regulations remain silent on whether and how OHCA will consider these benefits. The regulations must be revised to affirm and enumerate OHCA's responsibilities to give the benefits of proposed transactions their proper consideration.

Clearly Formulate Criteria for Determining Whether to Conduct a Full CMIR. While the draft regulations list the factors OHCA will consider when determining whether to conduct or waive a full CMIR, they continue to provide no clarity about how OHCA will evaluate those factors. In fact, the draft regulations allow OHCA to make arbitrary decisions about which transactions will be subject to a CMIR based entirely on lax speculation. As a result, health care entities would have little to no ability to anticipate whether an intended transaction would receive a waiver within 60 days or be delayed by 250 or more days. We strongly encourage OHCA to conform these criteria with the statutory imperative requiring OHCA to review transactions likely to have significant effects on the market.

Reasonable Information Submission Requirements for Parties to a Transaction. We remain concerned that the information submission requirements on parties to a transaction place unnecessary burdens on health care entities, increase compliance costs, and exacerbate the risk that sensitive and confidential information will be released into the public domain. Accordingly, the information submission requirements — as currently drafted — should be scaled back to balance OHCA's need for information with the negative impacts that overly onerous reporting requirements would have on health care entities' basic market activities. In addition to several other requested changes, we recommend OHCA limit the submission requirements accompanying an initial notice of a material change to those of Massachusetts and Oregon, as well as California state agencies, including the Department of Justice. Additional information necessary to inform a full CMIR should be collected only when OHCA elects to conduct a full review following a waiver decision (or, at minimum, after OHCA elects not to grant a request for an expedited review). Finally, we ask for technical changes to the definition of revenues for information submission purposes.

Protect Sensitive Non-Public Information Provided to OHCA. We appreciate that OHCA has the difficult task of balancing public transparency with the parties' rights to keep sensitive proprietary information confidential. CHA recommends that Hart-Scott-Rodino filings, competitively sensitive information, and contact information for individuals other than the designated public contact be deemed confidential. In addition, we request that OHCA provide an opportunity for the submitter to appeal the denial before OHCA makes the information public.

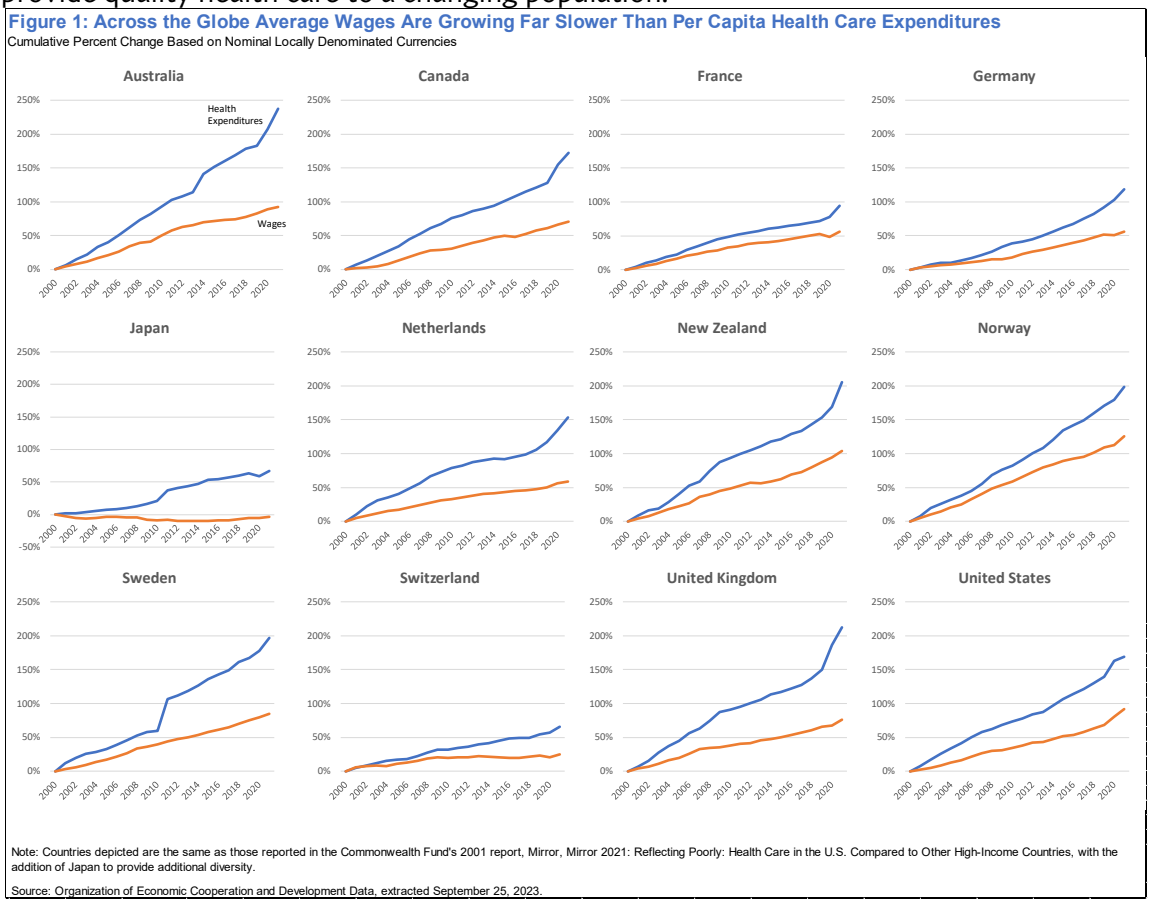
Spending Targets

The September board and advisory committee meetings included the first in-depth discussions of the design of the spending targets. These discussions were extremely valuable. However, certain important perspectives were missing.

We Urge OHCA to Strive for an Affordable *and* High-Performing Health Care System. Unfortunately, the presentation and subsequent discussion on the spending targets focused on only one of OHCA's multipronged objectives—that of affordability While we agree on the importance of considering how the economic experiences of California households relate to economic indicators that could be used as spending targets, we believe this cannot be the only consideration for setting an appropriate and workable spending target. Specifically, it may not be possible to realize a high-performing health-care system under the constraints of a spending target equal to the economic indicators considered during the September discussions.

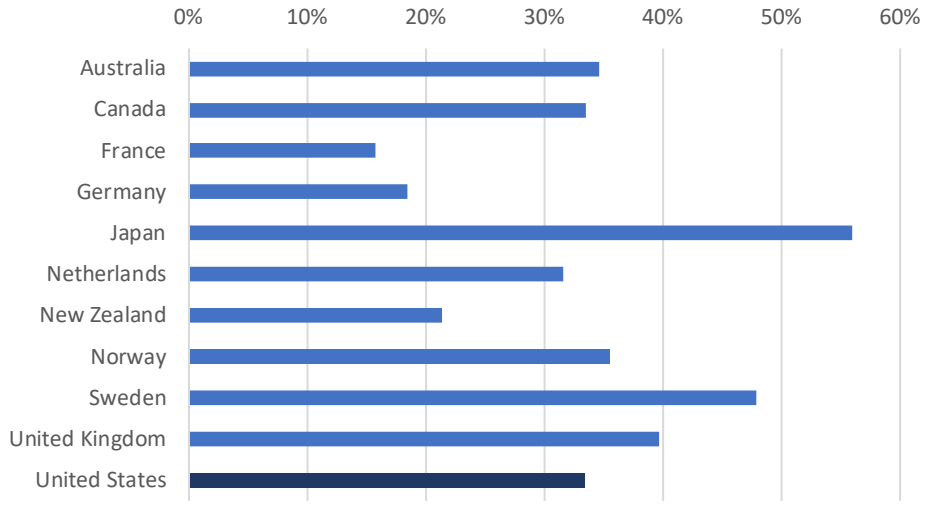
A Spending Target Exclusively Based on Wage or Income Growth Would Bring Serious Downside Risks. Spending targets based on measures of average or median income or wage growth are intended to limit health care spending growth to what individual families can afford. We understand the intuitive appeal of this approach, as voiced by members of the board and advisory committee. However, a deeper look at these measures reveals that they are inconsistent with the underlying realities of supporting even a highly cost-effective health care system.

- **Peer Countries Do Not Experience Health Care Cost Growth at Levels Comparable to Wage Growth…** The United States' peer countries include those with a wide array of health care systems and health care cost containment strategies. If a proposed spending growth target such as average wages were readily attainable, we would expect at least one of America's peers countries to have attained it. However, as shown in Figure 1, none of the 11 peer countries analyzed have seen their per capita health expenditures grow below, or even near, average wages. In fact, between 2000 and 2019, the growth rate for per capita health expenditures was roughly double that for average wages. The consistency of these trends across countries with diverse health care systems indicates that this divergence is not simply due to health care policy differences. Otherwise, we would not expect to see similar trends across countries. For example, if different levels of regulation were the key driver, we would expect divergent trends between countries with highly centralized and regulated systems (e.g., Canada and United Kingdom) and countries that are less regulated or more market oriented (e.g., the U.S. and the Netherlands). What this suggests is that underlying economic and demographic factors are key drivers of the higher growth in health expenditures. Therefore, limiting health care cost growth to a measure of wage growth risks seriously undermining the capacity of California's health care system to provide quality health care to a changing population.



- **…Or Even at Gross Domestic Product (GDP) Growth Levels.** Figure 2 shows that health expenditures have increased as a share of GDP in all the peer countries analyzed over roughly the last 20 years. Necessarily, this indicates that health care costs have grown at a faster rate than overall GDP in these countries, raising the question of whether even a GDP-based spending target could bring unintended negative consequences.

Figure 2: Across the Globe Health Expenditures Are Growing as a Share of GDP
Percent Change Between 2000 and 2019



GDP = gross domestic product.

- **Household Consumption Patterns Do Not Remain Fixed Over Time.** Households' and society's consumption patterns change over time as incomes grow, technologies evolve, and labor market dynamics shift. For example, households may spend significantly less of their income on goods subject to significant technological and cost-saving innovation (e.g., televisions). Alternatively, they may shift expenditures toward certain goods and services as their incomes increase. For example, while Americans' incomes have grown in the aggregate by 175% since 2000, their spending on restaurant meals has increased by over 300%, spending on hotels and other accommodations increased by nearly 225%, and spending on internet access increased by over 700%.[1] Two major patterns help explain which types of expenditures are likely to grow faster than income. First, industries that are labor intensive (that is, they employ many people and relatively fewer machines) tend to grow relatively more expensive over time, as they do not benefit as much from cost-saving automation as do more capital-intensive industries. Labor is a major input in the health care sector (as it is for restaurants and hotels),[2] including for hospitals where labor expenses comprise around 60% of total expenses. Second, industries that introduce major new products through technological innovation also tend to grow more rapidly than industries focused

[1] The higher growth in expenditures on these goods and services than in incomes necessarily implies that the share of income that households are spending on these goods and services has increased. For example, the share of income that Americans are spending on restaurant meals has increased by 57% since 2000, an increase that is greater than or comparable to that for health care among the peer countries compared in Figure 2.
[2] Bates, Laurie J., and Rexford E. Santerre. "Does the U.S. Health Care Sector Suffer from Baumol's Cost Disease? Evidence from the 50 States." Journal of Health Economics, vol. 32, no. 2, Mar. 2013, pp. 386–391, https://doi.org/10.1016/j.jhealeco.2012.12.003. Accessed 15 Aug. 2020.

on refining and improving existing products. Health care is a dynamic sector that regularly introduces revolutionary new and often expensive treatments that are then quickly adopted, a dynamic similar to the widespread adoption of internet access since 2000. In addition to these larger economic trends, demographic trends like aging cause a shift in income shares spent on health care. In the European Union, for example, aging alone is expected to increase the share of GDP spent on health care by 1.3 percentage points over the next 40 years.[3] These trends show how tying health care expenditure growth to economic indicators unrelated to the underlying drivers of health care cost growth could lead to harmful underinvestment in the sector.

We encourage the board and OHCA to incorporate these considerations into their future discussions, and ultimately into the spending targets and related methodologies they adopt. Such considerations could be formally incorporated into the targets in multiple ways, such as: the selection of economic and demographic indicators that tie more closely to the underlying drivers of health care costs, aggregating multiple such indicators into a spending target, and through adopting adjustment factors that ultimately result in a reasonable and attainable target.

Risk Adjustment

OHCA's Approach to Risk Adjustment Continues to Raise Concerns. At the September board meeting, OHCA announced its decision to risk adjust health care entities' spending data only on the basis of age and sex. With this decision, OHCA will forego clinical risk-adjustment approaches that perform orders of magnitude better than age and sex in explaining variation in health care spending. We worry that this will expose health care entities to potential enforcement action due to forces beyond their control—in this case, year-to-year fluctuations in the risk profile of their patient populations. In doing so, the spending target program will disincentivize health care entities from serving the highest risk and cost patients, which is inconsistent with supporting an equitable health care system.

Case Study: Risk Selection Hurts Black Infant Health. Several high-quality studies have demonstrated that failing to account for risk differences within payment methodologies can result in worse health outcomes, particularly for vulnerable populations.[4] A notable study of Texas's Medicaid program showed how Black infants — but not Hispanic infants — suffered higher morbidity and mortality rates when the program transitioned from fee for service to managed care, and thereby introduced new opportunities for risk selection.[5] While managed care plans received identical payments for Black and Hispanic infants,

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[3] Williams, Gemma A., et al. How Will Population Ageing Affect Health Expenditure Growth? Www.ncbi.nlm.nih.gov, European Observatory on Health Systems and Policies, 2019, www.ncbi.nlm.nih.gov/books/NBK550603/.

[4] In addition to the study described in detail in the body, see the following for evidence of the negative impact that unmitigated risk selection can have on vulnerable populations, including high-cost patients generally and cancer patients specifically:

- Wynand P. M. M. van de Ven, Richard C. van Kleef, and Rene C. J. A. van Vliet; Risk Selection Threatens Quality of Care for Certain Patients: Lessons from Europe's Health Insurance Exchanges; Health Affairs 2015 34:10, 1713-1720
- Kreider, Amanda and Layton, Timothy J. and Shepard, Mark and Wallace, Jacob, Adverse Selection and Network Design Under Regulated Plan Prices: Evidence from Medicaid (December 2022). NBER Working Paper No. w30719, Available at SSRN: https://ssrn.com/abstract=4293632

[5] Kuziemko, Ilyana and Meckel, Katherine and Rossin-Slater, Maya, Do Insurers Risk-Select Against Each Other? Evidence from Medicaid and Implications for Health Reform (July 2013). NBER Working Paper No. w19198, Available at SSRN: https://ssrn.com/abstract=2289108

black infants' hospital charges were 80% higher due to their more complicated labor and deliveries. In response to this predictable variation in costs, the authors concluded that the managed care plans had taken actions to enroll and retain more of the relatively lower cost Hispanic enrollees, while doing the opposite for the Black enrollees. Consequently, Black infants suffered even worse health outcomes due to a lack of appropriate preventive care, further widening already unacceptable disparities. Incorporating appropriate models of risk adjustment could have reduced these poor incentives and the resulting damage to Black infant health. However, sex- and age-only risk adjustment could have done nothing to prevent the harm mediated by racial risk differences.

Recommend an Alternative Approach of Testing Multiple Risk Adjustment Models. We appreciate OHCA's stated willingness to reconsider in the future its approach to conducting risk adjustment only on the basis of sex and age. However, without testing and comparing the outcomes of the two distinct approaches to risk adjustment, it is unclear what information OHCA would use as the basis of a future change in approach. Accordingly, we recommend that OHCA simultaneously pilot the two forms of risk adjustment and decide, with information in hand, on the appropriate approach on an ongoing basis.

Patient Attribution

As we have noted in prior letters and testimony, holding providers appropriately accountable against the spending targets will depend on accuracy of the patient attribution methodology. We request early engagement with providers to ensure that the methodology OHCA adopts is clearly prescribed in regulation, transparent, open in practice to validation by providers, designed to minimize cases of misattribution, and calibrated to cover only those providers that have a meaningful influence on their patients' utilization patterns and costs.

Thank you for the opportunity to comment on these important matters currently under consideration by OHCA, the board, and advisory committee.

Sincerely,

Ben Johnson

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