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Health Care Affordability Board Meeting

September 19, 2023

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Welcome, Call to Order, and Roll Call

AGENDA

1. **Welcome, Call to Order, and Roll Call**
   Secretary Mark Ghaly, Chair

2. **Executive Updates**
   Elizabeth Landsberg, Director, and Vishaal Pegany, Deputy Director

3. **Action Consent Items**
   Vishaal Pegany
   a. Approval of the August 22, 2023 Meeting Minutes

4. **Informational Items**
   a. Total Health Care Expenditures Measurement including September Advisory Committee Member Feedback; Overview of OHCA Draft Decisions for Baseline Report; and Introduction to Methodology Considerations for the Statewide Spending Target
      Vishaal Pegany, CJ Howard, Assistant Deputy Director, and Michael Bailit, Bailit Health

   b. Cost and Market Impact Review (CMIR) including Overview of Public Input on CMIR Regulations and Submission to the Office of Administrative Law
      Sheila Tatayon, Assistant Deputy Director

5. **Public Comment**

6. **Adjournment**

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Executive Updates

Elizabeth Landsberg, Director
Vishaal Pegany, Deputy Director

Slide Formatting

Indicates informational items for the Board and decision items for OHCA

Indicates current or future action items for the Board

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Action Consent Item: Approval of the August 22, 2023 Board Meeting Minutes

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Informational Items

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Total Health Care Expenditures (THCE) Measurement

Vishaal Pegany, Deputy Director
CJ Howard, Assistant Deputy Director
Michael Bailit, Bailit Health

Discussion Today

1. Consider Advisory Committee input regarding the August Board meeting THCE discussion.

2. Review major Office of Health Care Affordability (OHCA) draft decisions for collecting 2022-2023 THCE data from payers and fully integrated delivery systems for the baseline report.

3. Review process and timeline for regulation promulgation.

4. Transition to discussion of setting the statewide spending target value(s).
   - Review statutory charge and target-setting provisions.
   - Begin discussion of indicators that could be used to set the target.

5. Consider Advisory Committee input regarding setting the statewide spending target value(s).

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Advisory Committee Feedback Total Health Care Expenditures (THCE)

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OHCA Draft Design Decisions on THCE Data Collection for the Baseline Report

OHCA 2022-2023 THCE Measurement: Summary of Key Draft Design Decisions

The next few slides will highlight OHCA's tentative decisions on the measurement methodology for the baseline report, summarized according to the following categories:

1. Spending that is being measured
2. Spending data sources
3. Spending analysis
4. Characterizing and understanding spending

1. Spending that is being measured

OHCA will measure:

- Spending for **residents of California**, regardless of where they seek care.
- **Claims payments**
  - Payments to providers for covered services.
- **Consumer out-of-pocket spending obligation**
  - Consumer obligation (i.e., copay, coinsurance, and deductible) for all claims for covered services.

1. Spending that is being measured (cont.)

OHCA will measure:

- **Non-Claims payments**
  - Population Health and Practice Infrastructure Payments
  - Performance Payments
  - Payments with Shared Savings and Recoupments
  - Capitation and Full Risk Payments
  - Other Non-Claims Payments
  - Pharmacy Rebates

2. Spending data sources

- **Commercial, Medicaid, and Medicare**: OHCA will collect aggregate health care spending data across all markets from carriers with 40,000 or more enrolled lives in their Commercial, Medi-Cal, or Medicare markets.
  - For non-Managed Care Organization (MCO) Medi-Cal spending, OHCA will collect spending data from the Department of Health Care Services (DHCS)
  - For Traditional Medicare (fee-for-service) spending and Part D, OHCA will collect spending data from the Centers for Medicare and Medicaid Services (CMS)

- **Other Spending:** for calculation of statewide THCE, OHCA will likely include:
  - Veterans Affairs
  - Indian Health Service
  - California Department of Corrections and Rehabilitation

- **Insurer administrative cost and profits** from federal and state reports, when data are available, and from insurers directly or financial statements when they are not.
  - CMS Center for Consumer Information and Insurance Oversight (CCIIO) for Commercial (examining DMHC as another possibility)
  - NAIC for Medi-Cal MCOs
  - NAIC for Medicare Advantage

3. Spending Analysis - Levels of Reporting THCE

1.State	2. Region	3. Market	4. Payer	5. Provider Entities	6. Service Category
State	25 Regions	Medicaid *(Fee-for-Service and Managed Care)*	Medicaid Managed Care Plans	Provider Entity A	Hospital Inpatient
		Medicare *(Fee-for-Service and Managed Care)*	Medicare Advantage Carriers	Provider Entity B	Hospital Outpatient
		Commercial *(Self- and Fully-Insured)*	Commercial Carriers *(including by product type)*	Provider Entity C	Professional
					Long-term care
					Retail Pharmacy
					Other

3. Spending Analysis – Service Category and Product Type

- **Service Category:** OHCA will collect spending data by service category, including:
  - Hospital Inpatient
  - Hospital Outpatient
  - Professional
  - Long-Term Care
  - Retail Pharmacy
  - Other claims not categorized (e.g., durable medical equipment, transportation).
- **Product Types:** OHCA will collect spending data separately by commercial HMO/capitated and PPO/EPO/FFS product lines.

3. Spending Analysis – Geography

OHCA intends to collect spending data to support geographic analysis by Covered California rating regions, except for Los Angeles County. For Los Angeles County, OHCA intends to collect data by Service Planning Areas.

Figure 16. Nineteen California ACA Rating Areas

4. Characterizing and understanding spending measurement

- **Confidence Intervals:** OHCA will collect standard deviations to enable the calculation of confidence intervals and assess variability in spending.
- **Demographic Risk Adjustment:** OHCA will collect age and sex data to enable demographic adjustment when measuring year-over-year spending growth at the payer and provider entity levels.
- **Truncation:** OHCA will not collect truncated spending at the payer and provider entity levels.

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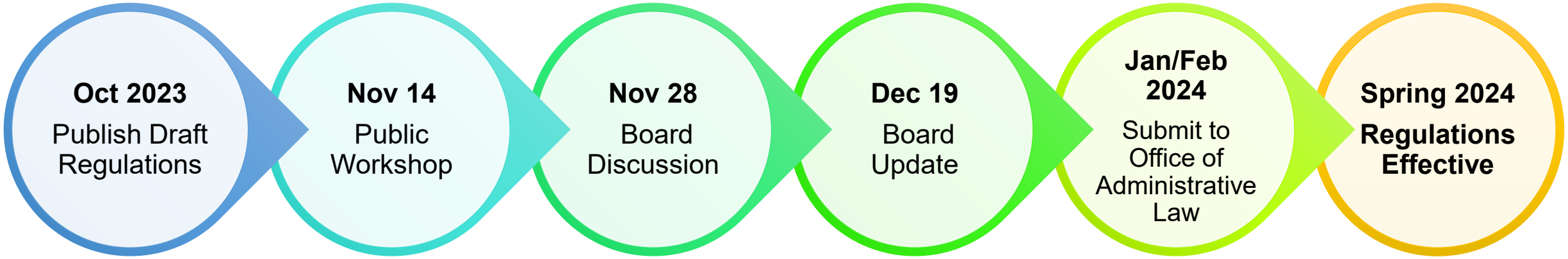
Timeline for Promulgating THCE Regulations

THCE Data Specification Regulations Timeline



Some dates are subject to change.

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Setting California's Health Care Spending Target

Review: What Is a Spending Target and Why Pursue One?

- A health care spending target is an annual rate of growth target.

- States have adopted such targets to slow the growth in health care spending.
  - Health spending growth has long exceeded economic growth.[1]
  - Per capita spending on health care has grown faster than inflation, wages and other consumer measures.[2]

1.Kaiser Family Foundation analysis of National Health Expenditure Data, February 2023 (https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/)
2. Ibid.

Developing California's Spending Target Methodology: Today's Goals

1. Review the statutory requirements and considerations, including the Board and OHCA responsibilities and timeline.
2. Review of other state's methodologies.
3. Introduce economic and population indicators and consider tying the target value to one or more of them.
   - Today we will define the indicators and describe the practical implications of tying the spending target to any of these. This will allow us to discuss the concepts in theoretical terms.
   - At our next meeting we will share historic and forecasted data for the measures that interest you the most and start the process of discussing the spending target value.
4. Review other factors identified in the statute for possible spending target adjustments.

Statutory Requirements for Setting the Target

The Board shall establish a statewide health care [spending] target for the 2025 calendar year and for each calendar year thereafter. The statewide target must meet the following criteria:

- Promote a **predictable and sustainable** rate of change in per capita THCE.
- Be based on a target percentage, with **consideration of economic indicators and/or population-based measures.**
- Be developed with a methodology that is **transparent** and available to the public.
- Be set **for each calendar year, with consideration of multi-year targets.**

* These criteria are summarized from Article 3. Health Care Cost Targets [Health and Safety Code section 127502].

Statutory Requirements for Setting the Target (cont.)

- Be **developed, applied and enforced**.
- Be **updated periodically** and consider relevant adjustment factors.
- Promote **improved affordability,** while maintaining **quality and equitable care**, including consideration of persons with disabilities and chronic illness.
- Promote the **stability of the health care workforce**.
- Be **adjusted for provider entities** to account for growth in organized labor costs.

* These criteria are summarized from Article 3. Health Care Cost Targets [Health and Safety Code section 127502].

Statutory Requirements for Setting the Target (cont.)

- The Board shall [also] establish specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate, except for fully integrated delivery systems.

- Sector targets must be established on or before June 1, 2028; therefore, the Board will focus only on the **statewide target** this year.*

*Per Health and Safety Code Section 127502: On or before October 1, 2027, the board shall define initial health care sectors. Not later than June 1, 2028, the board shall establish specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate, in accordance with this chapter.

Health Care Spending Target Methodology Development

OHCA is responsible for developing a methodology, to be approved by the Board. The methodology must meet the following criteria*:

- Be available and **transparent** to the public.
- Based on a review of **historical trends and projections** (forecasts) of economic and population-based measures.
- Based on a review of historical cost trends, with **differential treatment for COVID-19 years.**
- Consider potential **factors to adjust future cost targets**, including but not limited to health care employment cost index, labor costs, CPI-U and other factors.
- Consider several **criteria related to Medi-Cal**, including but not limited to the non-federal share of spending, maintaining federal requirements to ensure full federal financial participation and health care related taxes or fees provide the non-federal share.

* These criteria are summarized from Article 3. Health Care Cost Targets [Health and Safety Code section 127502].

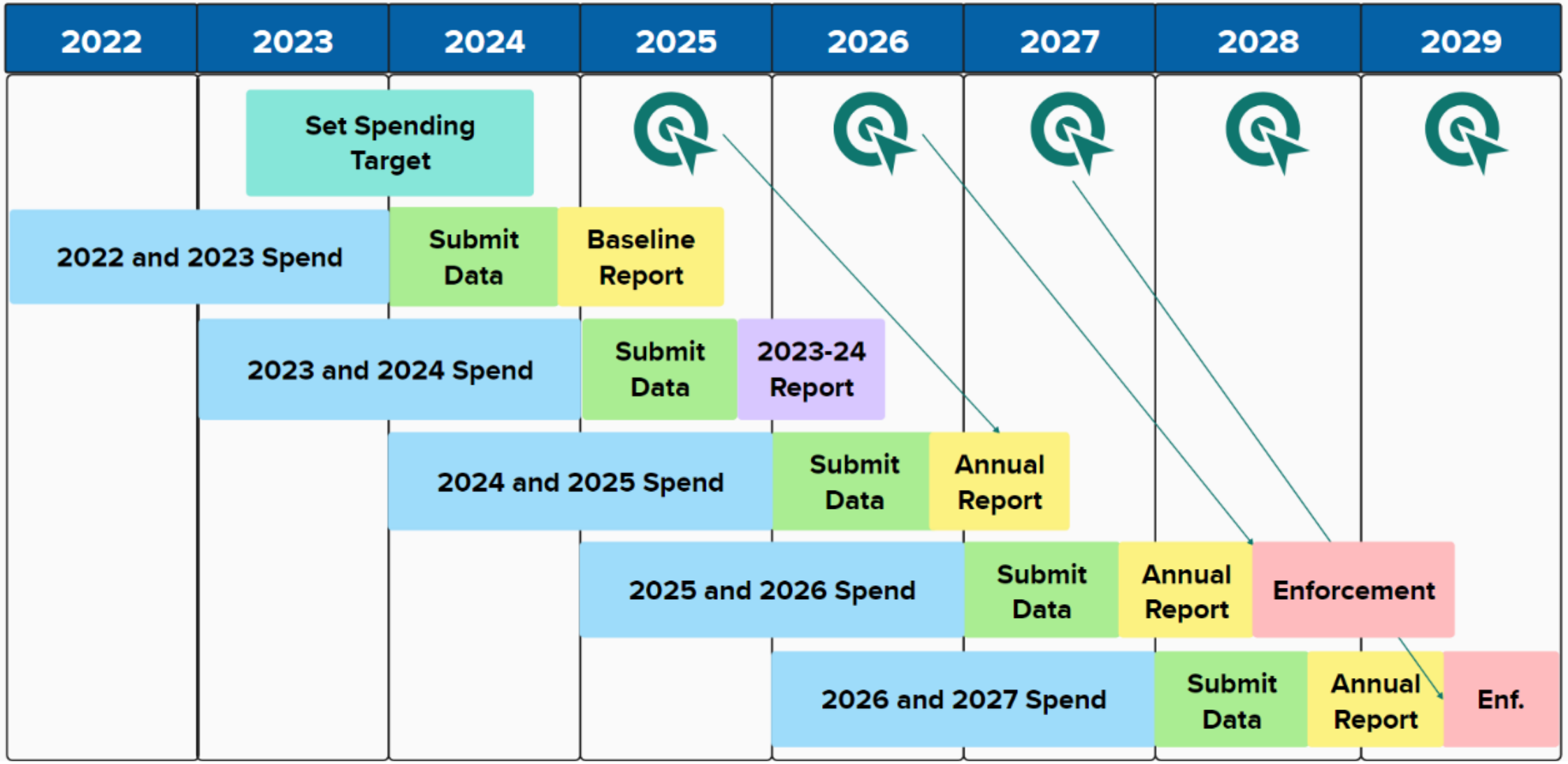
Health Care Spending Target Methodology Development (cont.)

- **Allow** the board to adjust cost targets downward, when warranted for health care entities that deliver high-cost care that is not commensurate with improvements in quality.
- **Allow** the board to adjust cost targets upward, when warranted, for health care entities that deliver low-cost, high-quality care.
- **Require** the board to adjust cost targets, as appropriate, for a provider or a fully integrated delivery system to account for actual or projected nonsupervisory employee organized labor costs.

Additional criteria apply when setting sector-specific targets. These will be reviewed during a future meeting.

* These criteria are summarized from Article 3. Health Care Cost Targets [Health and Safety Code section 127502].

Spending Target Timeline



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How Other States Have Set Their Spending Targets

- To date, eight states have set health care spending targets (CT, DE, MA, NJ, NV, OR, RI, WA).
- All tied their targets to some measure of the economy, including state economic growth and/or indicators of resident income growth.
- For most states, the governing body reviewed several different economic indicators and considered:
  - What the indicator measured, and how relevant it was to their charge?
  - What would be “the message” if they linked future health care spending growth to the indicator?

How Other States Have Set Their Spending Targets (cont.)

- When setting the values, states also considered prior spending growth in their state commercial, Medicaid, and Medicare markets.
- All of the states set multi-year targets at the outset. One state for as few as four years, one for as long as 10. Most set five-year targets.
- Between 2018 and 2022, states established target values ranging from 2.9 percent to 3.8 percent.
  - Target values were roughly 2 percentage points less than the average annual state health care spending growth over the prior decade in each state.

State Cost Growth Target Methodologies

State	Target Methodology	Target Value	Avg Annual Spending Growth (2011-2020)
Connecticut	80/20 blend of forecasted median wage and Potential Gross State Product (PGSP) Add-on factors: +0.5% for CY 2021, +0.3% for CY2022, +0.0% for CY 2023-2025	3.4% for 2021 3.2% for 2020 2.9% for 2023-2025	3.9%
Delaware	PGSP Add-on factors: +0.25% for 2021, +0.0% for CY2022-2023	3.8% for 2019 3.5% for 2020 3.25% for 2021 3.0% for 2022-2023	5.2%
Massachusetts	2018-2022: PGSP (3.6% in 2018) minus 0.5 2023 and beyond: default rate of PGSP	3.6% for 2013-2017 3.1% for 2018-2022 3.6% for 2023-2024	5.4%
Nevada	Changing blend of forecasted median wage and PGSP, with increasing weight on forecasted median wage over time.	3.19% for 2022 2.98% for 2023 2.78% for 2024 2.58% for 2025 2.37% for 2026	6.2%

State Cost Growth Target Methodologies

State	Target Methodology	Target Value	Avg Annual Spending Growth (2011-2020)
New Jersey	75/25 blend of median projected household income and PGSP Add-on factors: +0.3% for 2023, +0.0% for 2024, -0.2% for 2025, -0.4% for CY2026-2027	3.5% for 2023 3.2% for 2024 3.0% for 2025 2.8% for 2026-2027	5.4%
Rhode Island	PGSP for 2019-2022; 75/25 blend of PGSP and median household income for 2023-2027 2023-2025 PGSP input accounts for lagged inflation impact; 2026 and 2027 utilize long-term inflation forecasts	3.2% for 2019-2022 6.0% for 2023 5.1% for 2024 3.6% for 2025 3.3% for 2026 and 2027	5.1%
Oregon	Non-formulaic consideration of: historical Gross State Product (GSP); historical median wage; CMS waiver & legislative growth caps applied to the state's Medicaid and publicly purchased programs	3.4% for 2021-2025 3.0% for 2026-2030	5.8%
Washington	70/30 blend of historical median wage and PGSP, with a downward adjustment starting in 2024	3.2% for 2022-2023 3.0% for 2024-2025 2.8% for 2026	4.9%

Development of Spending Target Methodology: Reviewing Possible Indicators

- The statute requires the spending target to consider economic indicators and population-based measures.
- We will review possible economic indicators and population-based measures based on publicly available and transparent data.

Development of Spending Target Methodology: Possible Economic & Population Indicators

The statute states that economic indicators may include established measures reflecting the broader economy, the labor markets, and consumer cost trends.

We will present several indicators for consideration and describe:

1. What each of these indicators represents.
2. What the “message” would be if the spending target was pegged to one of these indicators.

Possible Economic and Population-Based Indicators

- California Gross State Product
- California's Potential Gross State Product
- Median Family Income of Californians
- Average Wage of Californians
- Inflation, as Measured by the Consumer Price Index (CPI-U)
- Median Age

* Each of these indicators would be calculated using annual growth rates.

What We Will Learn About Each of the Indicators

What each indicator measures

What the “message” would be if the target was pegged to one of these indicators

What the annual rate of change has been and (when available) forecasted data. (These data will be shared during the October meeting.)

Economic Indicators: Historical and Forecasted Experience

There are differences in economic indicators calculated using historical actual data vs. forecasts. We will consider both.

Historical Data

- Historical data reflects, to varying degrees, the volatility of year-over-year changes, including booms and busts, and pandemic times and healthier times.
- Historical figures are relatively easy mathematical calculations (straight average growth over prior time periods).
- Unexpected events can be addressed through smoothing or by extending the time period.

Forecasted Data

- Forecasted data are designed to be predictable, stable figures and are calculated by government agencies and private firms.
- The California Department of Finance regularly forecasts economic indicators for use in budget setting and for other purposes.
- Methods of forecasting vary by the organization performing the forecast, including by the philosophy and outlook of chief economists at each organization.

1. California Gross State Product

- **Gross State Product (GSP)** is the total value of goods produced and services provided in a state during a defined time period.
- This is the state counterpart to Gross Domestic Product (GDP), which is measured at the national level, with a few methodological differences in how the figures are calculated.

GSP is often considered the main measure and key target of economic policy at all levels of government. The growth in GSP tells us how fast the state's economy is growing.

Tying the benchmark to GSP signals that health care spending should not grow faster than the economy.

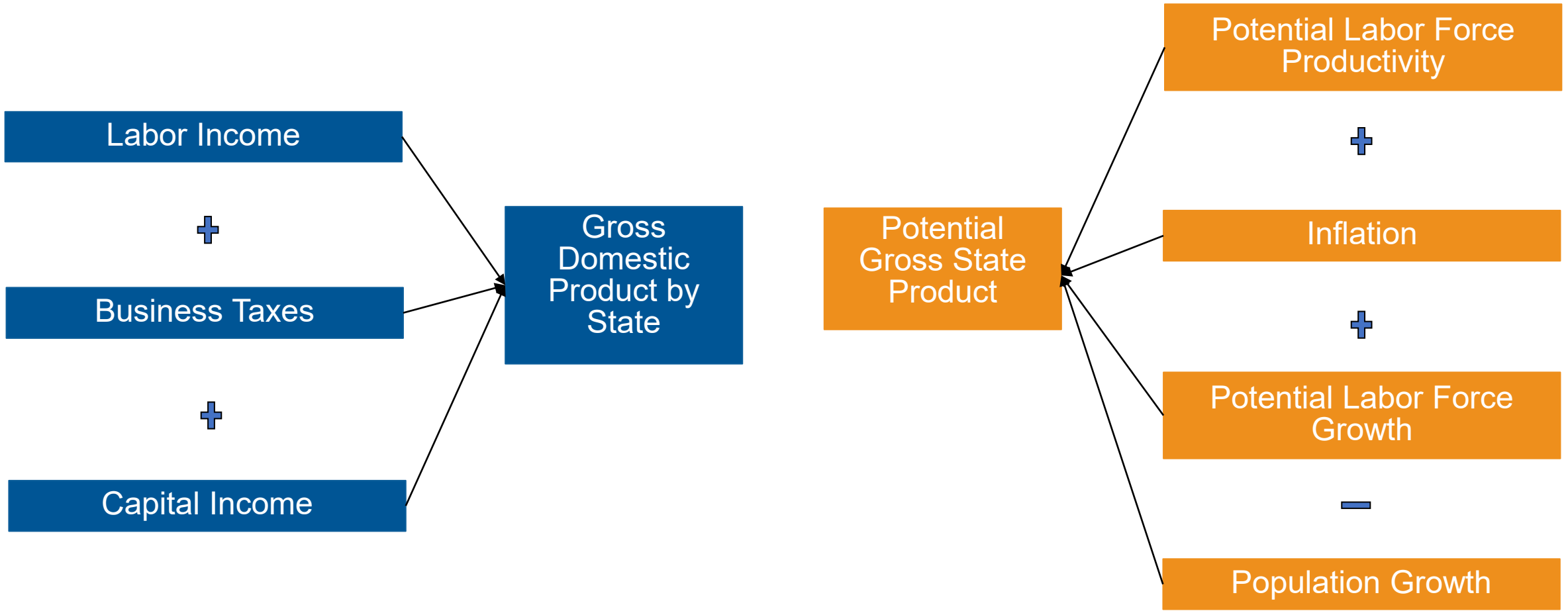
2. California's Potential Gross State Product (PGSP)

- **Potential Gross State Product (PGSP)** measures the long-run average growth rate of a state economy, excluding fluctuations that may occur due to the business cycle.
- It differs from GSP in that it is a forecasted measure of the economy and takes into account labor force productivity and participation, and inflation.

PGSP shows us what state economic growth is likely to be in the future. It is designed to be a stable benchmarking figure, one that many cost growth target states use.

Tying the benchmark to PGSP signals that health care spending should not grow faster than the state economy is forecasted to grow.

How GSP and PGSP Measures Differ



3. Median Family Income of Californians

- **Median Family Income** measures the long-run median growth rate of all income in a household among members related by blood, marriage, or adoption.
- Family income reflects that family members often pool their resources (and expenses).

Median family income represents the financial health of families in the state and their purchasing power.

Tying the target to median family income signals that health care spending should not grow faster than the income of California's families.

4. Average Wage of Californians

- **Wage Growth** measures the change in compensation individuals receive for work as an employee or a contractor with an employer. It doesn't capture income such as capital gains, dividends, rent, or interest. Wage growth does not factor in inflation.
- Wages have risen in California and recovered to pre-pandemic levels, but wages are down in the context of inflation.*

Wage growth closely represents "take-home pay" for most individuals within a state.

Tying the spending target to wage growth for California residents signals that health care spending should not grow faster than CA residents' "paychecks."

"Inflation squeezes Californians' budgets despite wage growth." Public Policy Institute of California. Blog post Nov. 3, 2022.

5. Inflation, Consumer Price Index (CPI)

- **Consumer Price Index (CPI)** is a measures price changes for a “market basket” of retail goods purchased out of pocket by consumers.
- It is most often measured using “CPI All Urban (CPI-U), which captures the experience of 94% of all Americans.

CPI measures inflation as experienced by consumers in their day-to-day living expenses and gives a sense of how prices have risen over time, and consumer purchasing power.

Setting the target to the rate of inflation signals that health care spending should not grow faster than the rise in consumer prices.

6. Median Age

- **Median Age** is a population indicator that may be measured to identify change in the state's demographics due to births, deaths, in-migration and out-migration.
- Researchers have found that aging contributes to health care growth, but how much it impacts *overall* growth relative to other factors is less clear.
- Note that OHCA is intending to measure year-over-year changes in age/sex at the plan and provider levels.

Median age growth rate measures the long-run demographic shift in the aging of a population.

Tying the spending target to growth in median age signals that the target needs to reflect any additional spending that may occur due to age.

Economic Indicators and Population-Based Measures

- Does the Board have questions or suggestions regarding use of one or more of the economic indicators or population-based measure previously reviewed?
- Are there additional economic indicators or population-based measures that you would like to consider? If so, which one(s), and why?

Potential Factors to Adjust Future Targets

The statute requires the methodology to consider possible adjustments for *at least* these potential factors:

- Health care employment cost index
- Labor costs
- Consumer Price Index- All Urban Consumers (CPI-U) *(included in the suite of economic indicators previously reviewed)*
- Impacts due to known emerging diseases
- Trends in the price of health care technologies
- Provider payer mix
- State or local mandates such as required capital improvement projects
- Relevant state and federal policy changes impacting covered benefits, provider reimbursement and costs

* These possible adjustments are summarized from Article 3. Health Care Cost Targets [Health and Safety Code section 127502].

Next Steps for the October Meeting

- We will start next month's meeting with a review of historic trends in the commercial, Medi-Cal and Medicare markets (where data are available).
- We will then share historic and forecasted (when available) data on growth rates of the economic and population-based indicators in which you expressed interest today.

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Advisory Committee Feedback from September 18, 2023: Setting California's Health Care Spending Target

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Cost and Market Impact Review (CMIR) Including Overview of Public Input on CMIR Regulations and Submission to the Office of Administrative Law

Sheila Tatayon, Assistant Deputy Director

Statutory Finding of Emergency for Rulemaking

Statute

Health and Safety Code §127501.2(a)

Until January 1, 2027, any necessary rules and regulations for the purpose of implementing this chapter may be adopted as **emergency regulations** in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The adoption of emergency regulations pursuant to this section shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare.

Emergency vs. Regular Rulemaking

Emergency Rulemaking

- Posted online for **5** days before submission to the Office of Administrative Law
- Comments may only relate to necessity of emergency
- Once approved, goes into effect the next day
- Will only last 5 years; must be followed by a regular rulemaking or else will expire

Regular Rulemaking

- Posted online for **45** days before submission to the Office of Administrative Law
- Comments on text must be summarized and responded to in the rulemaking file
- Once approved, usually goes into effect the following quarter
- Permanent

Overview of Written Comments on Proposed CMIR Regulations

- A total of 20 comment letters were received.
  Six letters came from organizations that had made verbal comments at the August 15th regulations workshop.

- Comment letters came from unions, physician groups, health plans, hospital systems, private equity, consumer advocacy groups, and medical, hospital, and nursing associations.

Written Comments Similar to Comments from the August 15th Workshop

Thresholds & Circumstances for Filing Notice

- Some commenters identified that the revenue thresholds for filing a material change notice were too low while others said they were not low enough. Instead of $10-25 Million, suggestions ranged from $3-6 Million to $50-100 Million.

Management Services Organizations (MSOs)

- Several commenters opposed the inclusion of MSOs in the definition of health care entity as “payers” and suggested they should be exempt from filing. Other written commenters, however, expressed a need for MSOs to be included.

Timing Issues

- Requests for clarity around the timing for filing a notice. Specifically, when OHCA would consider a transaction *closed*.
- Concern at the length of time needed to review notices and conduct CMIRs.
- Requests for an expedited review process.

Written Comments Similar to Comments from the August 15th Workshop (cont.)

CMIR Criteria / Factors

- Several commenters suggested the review criteria / thresholds were too broad. Others wanted more criteria.
- Requested clarification and inclusion of factors for consideration of the benefits of the transaction.
- Requested inclusion of the full range of reproductive and sexual health services including contraception, abortion, and LGBTQ+ health services.
- Requested inclusion of behavioral health services.
- Requested including labor market impacts as a sole reason for conducting a CMIR.

Written Comments Similar to Comments from the August 15th Workshop (cont.)

Confidentiality

- Requests that that additional documents be expressly confidential.
- Requests that additional attestations be made with requests for confidential treatment of documents, to ensure that submitters verify they have always maintained these documents as confidential.

Reporting requirements

- Commenters suggested two additional reporting requirements when filing:
  (1) the source of funding for the transaction and
  (2) the evidence used to determine that a transaction is beneficial.

Public Input into CMIR process

- Requests for additional public input (including hearings) in the review process.

Fees

- Requested capping reimbursement (fees).

Additional Issues Raised from Written Comments

Definitions

- Support and Opposition to broaden (make more inclusive) / narrow: **Transactions**
- Support and Opposition to broaden (include parents) / narrow (exclude categories): **Affiliates**

Thresholds & Circumstances for Filing Notice

- Requests to require more detail on **Labor/staffing**, **Benefits** proposed from transaction
- Requests to require less detail for material filed (burdensome)
- Support and Opposition to revenue definitions, materiality, control

Requests for more “Market Failure” text

Support and Opposition for “look-backs” / prior transactions

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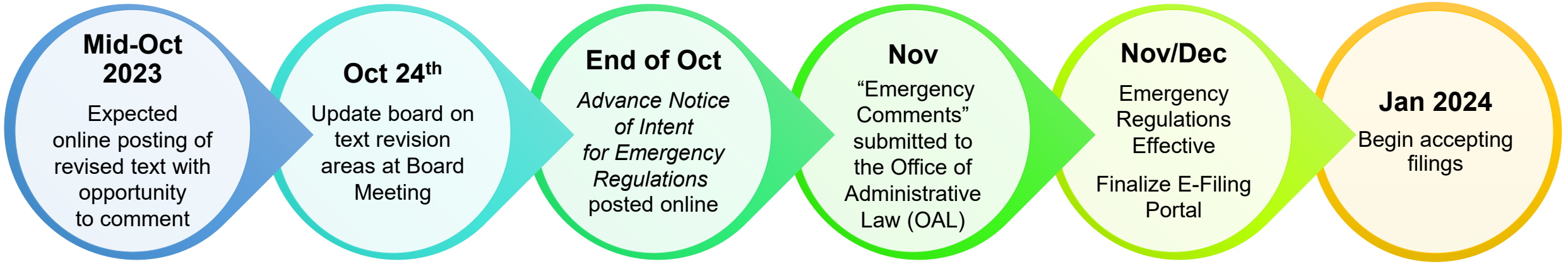
Advisory Committee Feedback from September 18, 2023: CMIR

CMIR Regulations and Timeline: Looking Ahead to January 1, 2024 Filings

OHCA will promulgate regulations under its emergency rulemaking authority as follows:



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General Public Comment

Written public comment can be emailed to: ohca@hcai.ca.gov

Next Meeting:

October 24, 2023
10:30 a.m.

Location:
2020 West El Camino Avenue
Sacramento, CA 95833

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Adjournment