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Health Care Affordability
Board September 19, 2023
MEETING MINUTES

Members Attending: David Carlisle, Sandra Hernández, Richard Kronick, Ian Lewis, Elizabeth Mitchell, Richard Pan

Members Not Present: Mark Ghaly, Don Moulds

Presenters: Elizabeth Landsberg, Director, HCAI; Vishaal Pegany, Deputy Director, HCAI; CJ Howard, Assistant Deputy Director, HCAI; Michael Bailit, Bailit Health; Brian Kearns, Assistant Chief Counsel

Meeting Recording: https://www.youtube.com/watch?v=JvZuPjMearE
Meeting Materials: https://hcai.ca.gov/public-meetings/september-health-care-affordability-board-meeting/

Agenda Item # 1: Welcome and Introduction
Sandra Hernández, sub-chair

Sandra Hernández opened the September meeting of California's Health Care Affordability Board. Six (6) Board members were present, establishing a quorum. Director Elizabeth Landsberg provided an overview of the agenda.

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

Director Landsberg and Deputy Director Pegany presented on this agenda item. Director Landsberg highlighted a report by Third Way that centers the healthcare affordability conversation on consumer needs and challenges. An update was given on the Health Care Payment Data (HPD) database, Health Workforce Development Programs, the Distressed Hospital Loan Program.

Public Comment on agenda item 2. No public comment.

Agenda Item # 3: Approval of August Meeting Minutes
Vishaal Pegany, Deputy Director, HCAI

Vishaal Pegany introduced the action item to approve the August meeting minutes. Board member Hernández invited a motion to approve. Board member David Carlisle motioned to approve, and member Ian Lewis seconded.

Public Comment on agenda item 3. No public comment.

The Board voted to accept. Board member Sandra Hernández abstained due to absence during the August meeting. The motion was passed.

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

Vishaal Pegany presented on Total Health Care Expenditures Measurement including September Advisory Committee Member Feedback. Board member Richard Pan added summary feedback. He highlighted that several advisory committee members were concerned that using only age/sex risk adjustment would not be a sufficient adjustment. Some of the advisory committee members referenced the need to make sure the methodology is sufficient to ensure confidence in the methodology and the targets set. Richard Pan shared the Advisory Committee had a desire to try to measure common out of pocket expenses and noted the challenge of lack of data, and that Advisory Committee members also spoke to capturing reinsurance appropriately.

Board members asked if there were any recommendations about how to capture consumer out of pocket spending for behavioral health considering the lack of a source of reliable data. Richard Pan replied that no solution was proposed by the Advisory Committee members.

Board members expressed concern with the implication that some data on spending will be estimates and others will be solid data when all the data they are working with is estimates, although some being more accurate than others. Board members also indicated that estimates for out of pocket spend on behavioral health, although they may be imprecise, would be better than nothing to be able to understand consumer affordability better. Deputy Director Pegany responded that THCE data would be actuals based on claims payments.

Some Board members expressed support for the planned approach of using only age/sex factors for risk adjustment and acknowledged the concerns the board has heard about the reliability of this approach. Board members stated they would continue to evaluate the topic in the future if there is a better methodology.

Other members expressed concerns around adverse selection in the current approach for risk adjustment. Specifically, this may incentivize some to pursue a strategy of avoiding people who have ongoing higher risk to keep cost down. Some are already gaming the system and that needs to be acknowledged.

Board members responded to the concern of using age/sex by stating that this adjustment is not being used to compare per capita spending across medical groups, rather it's being used to compare growth in spending over time for a health care entity. It was also noted that there is not much evidence that the risk or the health status of the patients cared for by medical groups significantly changes from one year to the next. Members noted that it's possible that the patient risk profile does change year to year, and the incentive problems raised are worrisome, but the issues are unbalanced and using clinical risk adjustment raises more problems.

Deputy Director Pegany stated the age/sex methodology would be the approach for the baseline report and they will continue to assess the issue of whether clinical risk adjustment should be introduced in future reporting. The Office is open to other approaches and will continue to assess options going forward.

Public Comment on agenda item 4a (See recording for comments).

Director Landsberg reiterated what a member of the public said on the equity side of using clinical risk adjustment and referenced a slide from a previous presentation from Michael Bailit on risk adjustment. The Massachusetts HPC did a presentation about risk adjustment with an example of two different mothers who had health conditions. The single mother who couldn't get time off work, delayed getting care, got sicker, but didn't go in to get her condition diagnosed. Then there was the affluent mother who could take time off work, who got her condition diagnosed and the provider had the ability to code that. That example illustrated the equity concerns with clinical risk adjustment. Another piece that was talked about was plan design and medical group considerations. This methodology will be applied to the same health plan or the same medical group's population to measure spending growth over time. Director Landsberg acknowledged that there will be some changes in a patient population from year to year but thinks the population is generally stable enough to have made a sound decision.

Vishaal Pegany and CJ Howard presented the Overview of OHCA Draft Decisions for the Baseline Report

Board members asked how OHCA will capture data from plans and is that going to include ERISA or self-funded plans?

Deputy Director Pegany replied that most states have been successful in getting self-insured plan data and commercial market data would aggregate fully insured and self-insured lives. The goal is to be working with the payer community on the data submission requirements.

Board members expressed that it was important not to discard options in the methodology too early in the process and asked where the Board landed on worker's compensation. Deputy

Director Pegany replied that it would involve working with an entirely different set of carriers that are not the health plans that they're used to working with. Director Landsberg added that HCAI doesn't have the authority and the definition of payers in the statute does not include workers' compensation.

Board members expressed hope that the baseline report would include rough estimates of both worker's comp and public health spending and have some plan for collecting this data in the future. Regarding primary care and behavioral health spend, Board members cautioned against using existing methodologies for defining behavioral and primary care spending without first engaging with stakeholders. Board members lamented the possibility of a baseline report without data on primary care and behavioral health spending. Deputy Director Pegany replied that the Office has struggled with that as well. With primary care, there has been a lot of great work done on this by various groups that have looked at the various service codes that should be included and care settings and provider types. OHCA needs to do broader stakeholder engagement to make sure, if they're going to expect entities or payers to report on this data, to get stakeholder input and recommendations. This won't be ready in time for the baseline report, just because of the timing of the cycles. For behavioral health, there's been less work done on defining this spending.

Members raised the topic of risk adjustment and how best to measure coding intensity. For example, estimates of Medicare Advantage plans have risk scores that are 14% higher than the risk scores for the same person if they were in fee for service. MedPAC's previous work about equity arguments that were raised, showing that there is a tremendous amount of heterogeneity among Medicare Advantage contracts, and it does not seem clear that clinical risk adjustment introduces more equity given the tremendous differences across plans on how coding is done.

Board members revisited levels of reporting and asked whether OHCA has considered reporting on actuarial value of health plans. Director Landsberg answered that if trend is lower for plans with lower actuarial value, that may not be a good thing in terms of equity, and it might be a sign of unmet need or increased consumer out of pocket out of plan spending that OHCA is not capturing because the data is imperfect. Deputy Director Pegany added that the Office has been tracking this issue in terms of what could be reported alongside THCE data as part of consumer affordability measures.

Board members commented that they thought OHCA would be aggregating the payer spending and the out-of-pocket consumer spending, on at least covered services to the extent they are collected. Board members suggested the Office look at how AV changes year to year.

Board members asked if HCAI is looking at home and community-based care as a key consideration for affordability. Members asked if there are other ways to get at some of the cost borne by consumers that might not be showing up in the hospital or facility data. Director Landsberg replied that OHCA would report on home and community-based services that are covered by Medi-Cal and other plans under long-term care.

Public Comment on agenda item 4a (See recording for comments).

CJ Howard presented the Introduction to Methodology Considerations for the Statewide

Spending Target.

Board members asked for confirmation that they are required to set sector targets by 2028, but enforcement starts in 2027, which implies that sector targets need to be decided well before 2028. Director Landsberg answered that the enforcement that would start in 2028 would be for the statewide target. In 2025, there will be a statewide target that's not enforceable. The first enforceable target year is 2026 [enforced in 2028]. The geographic or industry sector targets that are set for 2028 would be enforced in 2030.

Board members asked if there is an option to have a spending growth target of zero for commercial and allow growth in Medicaid and still get the same average. Or could you set a regional target of zero or a negative target for Monterey and increase the target in other underserved regions? Director Landsberg replied that you could have a different target for Medi-Cal versus commercial coverage or regionally, on or before 2028. The Board has discretion to set the sector targets no later than June 2028, but they cannot be negative since they are based on growth.

Michael Bailit continued the presentation on the Introduction to Methodology Considerations for the Statewide Spending Target and discussed how other states have set their spending targets. Board members asked if Michael has seen in other states, entities increasing their rates because in anticipation of these targets. Michael Bailit replied that he had not, due to most payer/provider contracts being multi-year contracts, which would limit that kind of flexibility. Board members asked if there was a way to calculate the 20%+ increases we are seeing today, and before setting the target, consider their pre-target spend and make any adjustments. Deputy Director Pegany replied that there is potential for a more-tailored approach to allow for a more aggressive target for a particular entity. Director Landsberg highlighted again that the limitation of the statute is that the Board cannot require a decrease in spending. The most the Board could do is a zero or 0.1% spending growth target.

Board members asked what the rationale is for blending different methodologies. Bailit replied that the states that blended methodologies (Connecticut and Nevada) did so because they felt that linking healthcare spending growth to state economic growth was insufficient, because it does not connect sufficiently to the patient or consumer experience. Other states decided to also introduce some consumer-oriented economic indicators. They didn't completely drop state economic growth, but they thought that they needed to have a balance of the two. Bailit noted that there are add on factors, which are the values that are added on top of what is identified as a long-term target. For example, the top Connecticut 2.9% was the result of their 80/20 blended calculation, but they decided to add half a percentage point for the first year and 0.3% for the second year to create a transitional path. There was not an empirical formula that got them to those add on values. Board members commented that in California, health-fund, large group contracts are typically a one-year period, which might be different from self-insured markets where provider contracts run several years. If health plans are reacting by driving up prices, that is a failure of the market to provide adequate competition and keep reasonable rates.

Michael Bailit continued to review the practices of other states. Board members asked about

enforcement practices in other states. Michael Bailit pointed out that Oregon is the most like California, with respect of financial penalties.

Board members asked if the other states had looked at the cost of providing care like Medicare does; Medicare rates, by law, reflect the cost of services and the research shows that hospitals should be able to provide equivalent care for a max of 160% of Medicare. Bailit replied that other states have not considered cost of providing care in their target setting, due to the focus of slowing health care spending so that it's affordable to consumers. Board members asked what period the forecasts are projecting, which is about 5 years.

Michael Bailit continued to present on economic measures. Board members asked what the source is of income data. If it is based on tax information, will the report miss people who don't pay income tax, or who don't file because their income is too low? Another Board member replied that states use data from the Current Population Survey (CPS), which is a household survey conducted by the federal government every month. There's a March supplement that gathers data on information from the prior year. It's not from the State Franchise Tax Board. The Census, which conducts a CPS, has a well-worn and time-tested method of defining households. Michael Bailit highlighted that is based on historical data and the Office is also looking to compare it with the use of forecast data. Board members discussed the importance of using median wage versus average wage as an appropriate measure.

Board members questioned the relevance of inflation as a consideration for hospital or healthcare prices and suggested looking at how much health care drives inflation across sectors. Board members commented that using median age related to spend is assumed to be linear and there should be a statistical curve calculation used to reflect it. A Board member suggested using information on spending by age group, like 5-year age and gender buckets, and calculate the effect of changing age distributions on expected spending and then have that as an add on to whatever indicator. Board members asked about the use of other population measures, did any of other states consider them and if not, why? Michael Bailit noted that in his experience, the issue of other population measures was never raised in other states.

Board members acknowledged and appreciated the recognition on the question of income inequality. California has among the very highest income inequality factors in the country. Income inequality and how it's tracked over time is getting worse and is an essential factor that the Board and the Office need to be thinking about, because gross state product doesn't account for income inequality.

Some Board members expressed support for the approach to using blended approaches of measurement. Deputy Director Pegany asked the Board for suggestions regarding the use of one or more of the economic indicators or additional population-based indicators. Board members reiterated the use of median wage over average wage and suggested in the next meeting to plan for consideration of the "add-on" factors that various states have used, particularly looking at the aging population.

Board members asked about the Advisory Committee discussion of the different population measures. Board member Pan noted that the Advisory Committee showed support of using median wage versus average wage, and a committee member had a concern about disabilities as a consideration.

A Board member noted that the new Consolidated Appropriation Act regulations require self-insured employers to confirm and demonstrate that rate increases are related to utilization. The results of these regulations should be factored into what the Office and Board is looking at.

Board members asked if there is a reason why most states have used projected performance over historic. Michael Bailit noted the issue of volatility of economic expansion and recessions. A Board member pointed out that the challenge with using forecasted data is that it should be cross checked with what really happened.

Board members asked if they are going to get a chance to also look at the market consolidations during this period, which is driving up costs. Deputy Director Pegany replied that the CMIR program is going to start receiving its first set of notices on January 1. For consolidation to date, there's plenty of research on existing consolidated, for example, the differences in health care costs between Northern and Southern California. This existing knowledge is a consideration on how the Board and the Office will slow spending growth and later set sector targets. Sector targets could be a more targeted way to address certain markets where costs and affordability are more problematic.

A Board member urged HCAI to also consider other indices. For example, there's a housing affordability index that looks at income debts and financial assets. Board members expressed appreciation of the immense amount of work being carried out to implement the transaction review process. It would be helpful to hear the thinking as to how the Office is going to approach market failure. Monterey needs to be an early focus of the program as well.

CJ Howard presented remaining Advisory Committee feedback.

Public Comment on agenda item 4a (See recording for comments).

Agenda Item # 4b: Cost and Market Impact Review (CMIR) including Overview of Public Input on CMIR Regulations and Submission to the Office of Administrative Law
Brian Kearns, Assistant Chief Counsel

Brian Kearns presented on this agenda item in the absence of Assistant Deputy Director, Sheila Tatayon, from the meeting.

Board member Pan reviewed the feedback from the Advisory Committee. He noted that people raised concerns about the breadth of filings and why the Office wanted to know about certain transactions. He expressed that the AC has concerns about confidentiality.

Board members expressed the desire to see the other 17 comment letters and a concern that the replacement of electronic health record would require or trigger a filing.

Brian Kearns noted that the letters would be available on the Office's website. He also commented that including health care technology is due to the nature of these transactions and the resultant impact on health care prices. Notices of these transactions would be informative to the public. Deputy Director Pegany noted that the Office is evaluating this issue and how to handle activities that are in the ordinary course of business.

Board members highlighted that focusing on market failures and on consolidation makes sense as a first foray and as the capabilities of the Office increase, potentially broadening would make sense as well. The Board member suggested thinking about starting with the highest priorities rather than trying to sweep in everything at once.

Agenda Item # 5: General Public Comment

The presiding Chair invited public comment.

Public Comment on agenda item 4 and General Public Comment (See recording for comments).

Agenda Item # 6: Adjournment

Sandra Hernández adjourned the meeting.