HCAi Department of Health Care Access and Information
2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833
hcai.ca.gov

Health Care Affordability Board
March 25, 2024
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
3/25/2024	Integrated Healthcare Association	See Attachment #1.
3/26/2024	Stephen Shortell	The OHCA board should stick with the proposed 3 percent state spending increase limit for the following reasons: 1) It is 5 years or more since Massachusetts and some other states enacted spending limits and California can and has learned from their experience. Not to do so by saying that we need a "ramp-up" period would be going back in time. 2) We have an infrastructure of strong medical groups and health systems that increasingly know how to improve care, remove waste and inefficiencies and thereby lower the rate of growth in costs. 3) Many of these groups operate under the "delegated model" in which they accept prospective financial risk for care and the IHA data show that they have better risk-adjusted clinical quality measures and lower total cost of care than those operating under fee-for-serve payment. 4) Many of the state's provider organizations have participated or are participating in advanced primary care initiatives such as those of the Purchasers Business Group on Health (PBGH) and the work of the California Quality Collaborative (CQC) providing the capabilities to do effective prevention, addressing the social drivers of health, reducing ED visits, and unnecessary hospital admissions. 5) Setting the target at 3 percent may result in some medical groups and health systems failing to meet the target than would be the case if the target were

Date	Name	Written Comment
		set higher but this will result in faster learning. The learning can be built into their performance improvement plans and they can also participate in "Improvement Collboboratives" in which they can learn from others who have achieved the target. Please acknowledge receipt of these comments.
4/9/2024	Kit Bear	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. I support the Office of Health Care Affordability's suggested statewide spending target of at most 3% without any further delays and without population or new technology adjustments. This target makes sure that health care costs don't outpace what every day Californians like myself can afford. I hope this board keeps my story in mind while making their decisions so Californians can better afford the health care we need to thrive.
4/19/2024	America's Physician Groups	See Attachment #2.
4/19/2024	San Francisco Health Service System	See Attachment #3.
4/19/2024	Health Access California	See Attachment #4.
4/20/2024	Sydney Pitcher	Mamy Californians face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, many Californians have to delay or ration care, or make difficult decisions about what to prioritize financially. It has also been said that people of color, indigenous people, people with disabilities, and other minority groups are more likely to face healthcare barriers and be unable to afford quality healthcare. Income, race, sexual orientation, gender, or a disability should never determine whether or not a person is worthy of receiving life-saving, affordable health care and should never determine the chances of someone's life being saved from a health condition or emergency they are forced to face. I really appreciate the progress we've made in California and around the country to make healthcare and prescription medication more

Date	Name	Written Comment
		affordable, as well as current programs already in place to help people but there is still much more work to do, because is totally unethical for pharmaceutical companies to price gouge, and make outrageous profits off the backs of suffering Americans. I support the Office of Health Care Affordability's suggested statewide spending target of at most 3% without any further delays and without population or new technology adjustments. This target makes sure that health care costs don't outpace what every day Californians like myself can afford. I hope this board keeps my story in mind while making their decisions so Californians can better afford the health care we need to thrive.
4/20/2024	California Hospital Association	See Attachment #5.

Attachment #1

Integrated Healthcare ASSOCIATION

180 Grand Avenue, Suite 1365
Oakland, California 94612

March 25, 2024

Via Email To:
ohca@hcai.ca.gov

Public Comment from Integrated Healthcare Association

IHA greatly appreciates the sharing of our data with the OHCA board on March 25, 2024, and we would welcome further discussion regarding how IHA information can support OHCA and the decision making ahead for OHCA management and the OHCA board.

IHA does not have a position on the 3% target, which is intentional. There are many opinions across the IHA board membership, which reflects the diversity of organizations that make up IHA. We do feel segmentation is necessary to understand how best any spending target would be applied across different geographies, different provider models and different plan lines of business. At the IHA board and executive committee meetings this week we are discussing whether a position on the 3% target is a step IHA should take.

Comments to consider/share coming from individual IHA member organizations include (partial list):

a. Some consideration of what is controllable vs. not controllable (such as new legislative requirements, new regulations, new benefit mandates) is warranted and should apply to all entities in the same way.

b. Assessment of the current total cost of care for individual organizations should be included (along with their quality and race/ethnicity performance) in any spending target as high costs will otherwise be "locked in". This is a form of segmentation but within a segment.

c. Whatever the overall spending target is, it makes more sense to set different targets for different segments (e.g. regions) or LOBs depending on how that segment is performing currently vs. applying a target to everyone equally.

d. While IHA does use a standard risk adjuster that includes clinical condition (and age/sex) across all the data we have, there are some that feel this still doesn't capture the full disease burden seen in PPO products. This may contribute to the rate increase differential highlighted between HMO and PPO networks.

e. Providers often manage costs across multiple LOBs, including Medicare, MA, MediCal, commercial HMO and commercial PPO. There is concern that an entity's target cost increases from OHCA (the "3%") would not consider rate increases from other payers that are often lower, such as Medicare and Medicaid. Holding commercial only to a target without considering what other payers are doing could mean some organizations will actually have an overall increase for their patient population that is lower than the target set by OHCA for commercial enrollment (and there still are uninsured populations in California).

Best regards,

Jeffrey A. Rideout MD, MA, FACP
CEO, the Integrated Healthcare Association (www.iha.org)

Attachment #2

AMERICA'S PHYSICIAN GROUPS

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

April 19, 2024

Re: Comments on Proposed Statewide Cost Target Adoption
(Submitted via Email to Megan Brubaker)

America's Physician Groups ("APG") supports the adoption of a phased-in cost target, in order to preserve the financial stability of the California "delegated model" physician organizations during the initial years of the Office of Health Care Affordability's oversight of California's health care market cost trend.

As APG has stated in numerous meetings of the OHCA Affordability Board and the Advisory Committee, the current trend for professionally capitated providers as reported by health plans to the Department of Managed Health Care in the periodic premium rate filings appears to have increased to approximately 5% since the advent of the COVID pandemic.

Those premium rate review filings also indicate that the professionally capitated provider segment has the lowest cost trend of all provider categories, which has been corroborated by recent data submitted by the Integrated Healthcare Association to the OHCA.

It is uncertain how a 3% statewide cost target would be implemented within the market and whether it means all contract renewals between health plans and capitated-delegated physician organizations would necessarily be renewed at lower rates than even the adopted cost target. If so, that would represent a sharp decrease in capitation rates of over 40%.

Cutting the rates of what has been shown to be the most cost-effective and efficient element of the provider community would be counterproductive to the other goals of workforce stability and expansion of alternative payment models within the OHCA charter.

As other provider representatives have pointed out, the states that monitor their statewide cost growth have been increasing their cost trend projections in recognition of the current market reality.

We acknowledge that it is difficult for a regulator to hit the "sweet spot" between a target number that produces meaningful relief for consumers without undermining the very delivery system that serves those consumers. While California was initially guided by the experience of the other states that adopted cost growth targets in formulating its OHCA, we suggest that it pay close attention to the actions of those states at present, including their increasingly conservative approach.

In light of these factors, APG suggests that the OHCA Affordability Board consider the alternative proposal that Secretary Ghaly has put forth, considering the more conservative trend across the country.

APG further suggests strong consideration of the proposal by the California Hospital Association for the adoption of an age modifier within the cost target. APG members provide the backbone of California's Medicare ambulatory delivery system. The continued financial solvency of that system is essential to honor the commitment California has made to its aging population.

Thank you for the opportunity to provide comment.

William Barcellona, Esq. MHA
Executive Vice President for Government Affairs
America's Physician Groups

wbarcellona@apg.org
(916) 606-6763

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

David M. Carlisle, MD, PhD
Secretary Dr. Mark Ghaly
Dr. Sandra Hernández
Dr. Richard Kronick
Ian Lewis
Elizabeth Mitchell
Donald B. Moulds, Ph.D.
Dr. Richard Pan

DocuSign Envelope ID: CEDBAC3B-614A-423D-AF0D-99474E54F693

Attachment #3

SAN FRANCISCO
HEALTH SERVICE SYSTEM

April 19, 2024

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

Subject:
Submitted via email to Megan Brubaker, OHCA@HCAI.ca.gov

Dear Dr. Ghaly:

The San Francisco Health Services System is pleased to support and comment on the statewide health care spending target as proposed by the Office of Health Care Affordability.

The San Francisco Health Service System purchases Health Insurance for over 120,000 persons; active and retired employees and their dependents employed by one of four public employers: the City and County of San Francisco, SF Unified School District, City College of San Francisco, and the Superior Court of San Francisco. The skyrocketing costs of healthcare directly increased the costs of benefit paid to these loyal government employees and their families.

SF Health Service System Employers are extremely concerned about the health care affordability crisis. Last year, the overall increase in the rates for health benefits of our members was 9.5%, double what was projected. All our employers testified at the February 2024 Meeting of the Health Service Board and spoke passionately about the current budget situation and that the rising cost of healthcare resulted in the increase in the costs of health benefits for their employees to the detriment of other services and programs. Our annual spend is rapidly approaching $1Billion dollars per year.

Also, the data presented at the Health Care Affordability Board has shown healthcare costs are too high and are increasing too rapidly. As government employers the rising cost of healthcare directly impacts the programs and services which the public needs and expects. SFHSS rates in place for the 2024 plan year are a full 9.5% higher than the prior year. We are currently awaiting proposed rates from our insurance carriers. We expect these costs to continue to rise because today there is no effective means to control the rising cost of healthcare.

SFHSS Recommendations

- The annual growth target should be no greater than 3%. Please note that ANY increase is on top of the high costs in place today and next year.

- Prospective exemptions to the target are premature and will only delay the implementation of the mandate. While it is true that the base year is quickly upon us (2025), in many ways it cannot come soon enough.

- There should be no delays or phase-in of the targets. As stated above, the rates are already too high and delaying the implementation will allow the ongoing rise in the cost of healthcare.

DocuSign Envelope ID: CEDBAC3B-614A-423D-AF0D-99474E54F693

Thank you for your continued consideration of the government purchaser voice in this initiative.

Sincerely,

DocuSigned by:
Abbie Yant RN, MA
237210E11644489...

Abbie Yant, RN, MA
Member Healthcare Advisory Board Advisory Committee
Executive Director
San Francisco Health Service System

HEALTH ACCESS CALIFORNIA

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

Anthony Wright
Executive Director

Organizations listed for identification purposes

April 17, 2024

Mark Ghaly, M.D., Chair
Health Care Affordability Board

Elizabeth Landsberg, Director,
Department of Health Care Access and Information

Vishaal Pegany, Deputy Director,
Office of Health Care Affordability
Department of Health Care Access and Information

2020 W. El Camino
Sacramento, CA 95814

Re: Proposed Spending Target for 2025-2029

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

Health Access California, the statewide health care consumer advocacy coalition, committed to quality, affordable health care for all Californians offers comments on the discussion about the proposed health care growth spending target for the five years from 2025 to 2029.

Executive Summary

- We continue to support basing the target on what consumers can afford, expressed as the median household income over the last 20 years.
- We oppose basing the target on existing trends in health care costs and current health care spending, business as usual. Business as usual will only worsen the lack of affordability that today denies consumers access, quality and equity.
- We support enforcement by market segment (Medicare, Medi-Cal and commercial coverage) as consistent with the enabling statute and justified by the policy differences among these sources of coverage.
- Given the consolidation in the health care market, a relatively small number of entities, perhaps as few as two or three dozen, finance or provide most of the care for most Californians. Tracking the performance of these entities against the target is manageable.
- We oppose, strongly, a one-year target as a functional delay of years in accountability and undermining predictability necessary for long-term planning.

What Most Consumers Can Afford?
Or Business as Usual: The Cost of Health Care?

What Consumers Can Afford

Virtually every penny of health care costs comes out of the pockets of consumers:

- As taxpayers, we pay directly for Medi-Cal, Medicare and Covered California subsidies.
- We also pay indirectly, and partially, for employer-sponsored insurance through the tax exclusion for employer coverage, the single largest tax benefit of the federal government.
- As workers, we pay indirectly in lost wages, up to $200,000 in the last 20 years for some in California or $125,000 in lost wages due to premium costs alone[1].
- As consumers, we pay premiums or share of premiums as well as copays, deductibles and co-insurance[2].
    - Twenty years ago, only one in three California workers had a deductible. Today, almost 80% of workers have a deductible and the median deductible is now $4,000, creating a barrier to needed care.
    - Premiums have doubled—and the share of premium paid by consumers has grown even more.

Enough is enough. Our goal is that health care costs reflect the ability of consumers to pay. That is what basing the target on median household income accomplishes.

This initial target should send a clear message about the need for change and to move away from business as usual, especially to those elements of the health care industry that fail to recognize the damage already done to consumers by the lack of affordability:

- Access: Half of California consumers skip or delay care because of lack of affordability. Half of those consumers got worse as a result.
- Quality: Positive health outcomes depend on regular access to care, including doctors, hospitals, and prescription drugs. Virtually every measure of quality for the major chronic conditions depends on seeing a doctor and taking necessary medications, something that too many consumers cannot do because of lack of affordability.
- Equity: The crisis of lack of affordability is worse for those in the bottom half of the income scale. And it is worse yet for communities of color[3].

Health Access continues to support the staff recommendation to base a five-year target for the years 2025-2029 on a twenty-year lookback at household median income which results in a 3% target for those five years.

On the question of whether there should be a "glide path" to this modest goal, we again point to the transition period built into this process, from the enactment of the law in 2022 to 2026, the first year of an enforceable target and we point to the decade or more of discussion about affordability in the legislative process that predated enactment. It has taken a decade (or more) to get to this step and it will take several more years before the target can be enforced. Even though this transition period should be sufficient, we recognize that such a major shift for some parts of the health care industry will take time and understand the proposal to start slightly higher than 3% in order to allow that time for changes to take effect. We urge that we get to 3% as soon as possible.

The Cost of Health Care: Business as Usual

A decade ago, when a hospital chain in Michigan hired a chief executive from the Ritz Carlton, the New York Times published a poll comparing the lobbies of fancy hotels with hospitals—and it was

[1] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2813927?resultClick=1 and JCC
[2] https://laborcenter.berkeley.edu/wp-content/uploads/2024/02/Measuring-Consumer-Affordability_revisedFeb82024.pdf
[3] https://www.chcf.org/wp-content/uploads/2024/01/2024CHCFCAHealthPolicySurvey.pdf

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

nearly impossible to distinguish. The irony is that even when the lobbies are not as nice, health care costs are far more expensive—which puts a burden on all who pay the bill. Given the medical staff and technology in a hospital, we do expect a week at Stanford Medical Center to be more than a week at the Stanford Park Hotel.[4] But it remains stunning than a week at the Stanford hospital costs more than a full semester at Stanford University.

Those who argue for business as usual, by simply codifying the current cost trends that are worsening the lack of affordability ignore the regressivity of the American health care system that relies on employer-sponsored coverage. Our system inflicts its costs the most on those consumers in the bottom 60% or 80% of the income scale, those consumers for whom staying in a hotel costing $460-$979 a night[5] would be incomprehensible. In virtually every other country with a universal coverage system, those systems do not base health care costs for the majority on the esthetic preferences of the top slices of the income scale. Those systems also do not rely on a regressive financing mechanism as does American employer-sponsored insurance. Instead in one way or another, other universal coverage systems scale costs to what consumers can afford. While in these other countries, some accommodation is made for the top 10% or 20% of the income scale[6], that is not accomplished by asking those who make the least to pay the most.

In another striking example, as the Board has repeatedly heard from those from Monterey, consumers in the bottom 60% of the income scale such as teachers, hotel workers, farm workers and others cannot afford their share of health care costs. This is because their health coverage requires coinsurance for hospital stays and other care, a response to the very high hospital costs driving up premiums. One health system in Monterey with a single hospital has a reserve of over $1 billion and is paid as much 559% of Medicare by commercial payers, a stunningly high price.

Yet commenters for most physician organizations and hospital systems propose basing the health care spending target on the cost of providing health care in recent years rather than moving to a system that begins to acknowledge the ability of consumers to afford care and coverage.

Integrated Healthcare Association Findings

The Integrated Healthcare Association, a trade association composed of health plans, hospitals, physician organizations, drug manufacturers and purchasers[7], has been the source of several reports and studies relevant to the spending target discussion and the work of OHCA more generally.

In brief, IHA has found that for commercial coverage in California:

- HMO spending per enrollee was substantially less than that for PPOs, consumer cost sharing is lower and the rate of growth in spending is higher.

[4] $909 per night. Accessed on website April 16, 2024.
[5] Price accessed through website of Ritz Carleton hotels for California locations on April 2, 2024.
[6] For example, when members of the British royal family were recently hospitalized for cancer treatment they went to "private" hospitals. But when Conservative Prime Minister Boris Johnson was hospitalized at the height of the Covid pandemic, he proudly went to a National Health Service hospital, just as most British citizens do.
[7] https://iha.org/our-members/board-of-directors/ downloaded April 12, 2024

- Together the IHA data includes HMO and PPO/EPO coverage that amounts to three quarters of the consumers with commercial coverage, including both fully insured and self-insured plans[8].

This goes hand in hand with two other findings from IHA's work that speak to OHCA's mission:

- First, for commercial coverage, HMOs rely more heavily on primary care and get better quality ratings[9].
- Second, again, for commercial coverage, HMOs have greater use of alternative payment models[10].

Enforcement of Target by Market Segment: Support

One of the questions raised at the March 2024 Board meeting was how the obligation of the Board to set a statewide cost growth spending target aligns with the proposal by staff to enforce targets by market segments, specifically Medicare, Medi-Cal and commercial coverage. The proposal of staff to base enforcement of the target by market segment is both consistent with the statute and sensible given the important differences in terms of rate setting authority among the market segments of Medicare, Medicaid and commercial coverage. If the target is set at 3%, then enforcement would look at whether spending attributed to Medicare lives grew by more than 3% and separately at whether spending attributed to Medi-Cal lives grew by more than 3% and then again separately at whether spending on commercial coverage grew by more than 3%. This approach also recognizes that the greatest need of consumers and other purchasers is to address the cost of the commercial coverage and that the Office has the greatest potential to affect that market segment.

Consistent with the Statute

It is correct that the law requires a statewide spending target. It is equally accurate that the law permits enforcement to account for differences among entities.

The law explicitly states:

> Article 3 Health Care Cost Targets, Section 127502
> (a) The board shall establish a statewide health care cost target.
> (b)-(k)[11]
> (j) **The office shall direct the public reporting of performance on the health care cost targets,** which **may** include analysis of changes in total health care expenditures on an aggregate and per capita basis for all of the following:
> (1) Statewide.
> (2) By geographic region[12].
> (3) **By insurance market and line of business**, including for each payer.

[8] https://www.dmhc.ca.gov/Portals/0/Docs/DO/FSSBFeb2024/AgendaItem5_HealthCareandQualityAtlas.pdf and slides 15-24
[9] https://www.chcf.org/wp-content/uploads/2022/04/InvestingPrimaryCareWhyItMattersCommercialCoverage.pdf
[10] Slide 21
[11] (b) sector targets, (c) requirements for targets, (d) office to develop target methodology for approval by board, (e) sector target methodology, (f) risk adjustment methodologies for data reporting on THCE, (g) office to establish equity adjustment methodologies, (h) payer MLR, (i) fully integrated delivery system targets.
[12] The Office has proposed, and the Board discussed last year preferred geographic regions, landing on a combination of the Covered California regions used for the individual and small group market rates as well as SPAs for Los Angeles County, a county larger than a dozen states.

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

(4) For health care entities, both unadjusted and using a risk adjustment methodology against the covered lives or patient populations, as applicable, for which they serve.
(5) For impact on affordability for consumers and purchasers of health care.
(emphasis added)

This provision (j) on public reporting of performance does NOT require defining sectors or developing sector targets. It governs the public reporting of the statewide health care target which the Board is now debating. Section 127500 (j) (3) makes it plain that the statewide target may be reported by insurance market and line of business, providing the statutory basis for the proposal to report by Medicare, Medi-Cal and commercial lines of business. This is what staff proposed at the March 25, 2024, Board meeting.

Section 127502.5 addresses enforcement of the targets. It reads:

127502.5.

(a) The director shall enforce the cost targets established by this chapter against health care entities in a manner that ensures compliance with targets, allows each health care entity opportunities for **remediation**, and ensures health care entities do not implement performance improvement plans in ways that are likely to erode access, quality, equity, or workforce stability. The director shall consider each entity's contribution to cost growth in excess of the applicable target and any actions by the entity that have eroded, or are likely to erode, access, quality, equity, or workforce stability, factors that contribute to spending in excess of the applicable target, and the extent to which each entity has control over the applicable components of its cost target. (emphasis added)

Taken together, Sections 127500 (a) which requires the Board to establish a statewide target, Section 127500 (j) which permits the Office to report by market segment, and Section 127502.5 (a) on enforcement provide the statutory basis for the proposal by staff to report and "enforce the statewide spending target based on the entity's performance by market"[13]. This would allow remediation by market segment which is appropriate in a policy sense as well as consistent with the statute.

Differences Among Market Segments: Medicare, Medi-Cal and Commercial

We support the proposed approach on a policy basis because important differences by market segment in rate setting authority make it prudent to treat different market segments differently, as proposed by staff.

1. Medicare

Medicare spending, both traditional Medicare and Medicare Advantage, are a substantial share of health care spending in California. Medicare rates, both fee-for-service and managed care, are designed to be sufficient for an efficiently run hospital or other type of provider. In the view of those who run Medicare, an efficiently run hospital or health system does not require Medicare rates sufficient to support sponsorship of sports stadiums or sports teams, interior decoration comparable to a luxury hotel lobby or major marketing campaigns.

[13] Slide 32, https://hcai.ca.gov/wp-content/uploads/2024/03/March-2024-Board-Meeting-Presentation.pdf

Because Medicare is a federal program with its own complex rate setting methodology, the Office has little ability to affect what Medicare pays.

2. Medi-Cal

In contrast to Medicare, the state plays an important role in administering the Medi-Cal program. While Medi-Cal is administered consistent with federal rules, each state, and California perhaps more than most, has a unique approach to the Medicaid program. In terms of supplemental payments, some of which rely on local match and others of which rely on various versions of provider taxes, how California spends the revenue from the supplemental payment funding streams is unusual among the states in its mix of base rate payments and supplemental payments. While this complicates the discussion of Medi-Cal, it does not justify exempting Medi-Cal spending from the OHCA law or oversight.

With respect to the rates paid to Medi-Cal managed care plans, we note that every Medicaid expansion has prompted disputes among the DHCS actuaries, the Legislative Analyst Office, and the advocates supporting those expansions over the cost of those expansions, including the per member per month cost. These differences in estimates have included the ACA expansion and each of the Health4All expansions to undocumented immigrants. In each of these instances, and more, robust discussion about the estimates of Medi-Cal costs by the DHCS actuaries led to further refinement of those estimates. Simply accepting the work of the DHCS actuaries without question would have had lamentable public policy results: we simply ask that OHCA be open to thinking through the Medi-Cal estimates in a way that further the goals of these two sister agencies.

The Medi-Cal program should be adequately funded but efficiently run, both by the state and the providers that serve those Californians who rely on it.

This Administration has made important improvements in the Medi-Cal program, from CalAIM to the new contracting requirements for Medi-Cal managed care plans to base rate improvements in some physician rates proposed for 2024 and 2025 as a result of the enhanced MCO tax. Organizations that have stepped forward to care for the Medi-Cal population should not be penalized by one part of the Administration for what another part of the same Administration has asked them to do.

We support the proposed approach in which "OHCA would not levy financial penalties on MCOs and/or their contracting providers solely due to operational or policy decisions made by DHCS[14]." Equally, we would oppose exempting Medi-Cal managed care plans and their contracting providers from oversight or enforcement by the Office.

3. Commercial, state regulated and self-insured plans:

In contrast to the rate setting authority of the Medicare and Medi-Cal programs, payers of commercial coverage lack rate setting authority because commercial payers are prohibited by anti-trust law from colluding to fix prices paid to providers. Only the government can intervene to set

[14] Slide 45 https://hcai.ca.gov/wp-content/uploads/2024/03/March-2024-Board-Meeting-Presentation.pdf

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

spending targets for the hospitals, physician organizations and health systems that contract with health plans for commercial coverage. While those providers reliant primarily on Medicare and Medi-Cal focus on balancing revenues and costs to make budget, those providers who scorn Medicare and Medi-Cal payments as insufficient get paid multiples of Medicare rates, often more than 200% of Medicare and as much as 500% or 600% or even 900% of Medicare. This latter group of providers are focused on revenue generation apparently without regard for either managing their own costs or the damage being done to consumers and other purchasers by lack of affordability. This approach has caused a lack of affordability so egregious that half of California consumers skip or delay necessary care, and some get worse as a result.

It is the cost of commercial coverage that is out of control. Reporting by separate market segments will highlight this and allow OHCA to meet its obligation to improve consumer affordability for those consumers who depend on employer coverage or unsubsidized individual coverage. We recommend that OHCA track not only year over year growth in commercial spending but also compare commercial payments to Medicare as a benchmark. A hospital that is getting paid 559% of Medicare by commercial payers is a high-cost outlier. An anesthesiologist seeking 900% of Medicare is a high-cost outlier. Limiting the growth in that already excessive spending to 3% per year is a good start but not sufficient.

OHCA can reach the claims costs of self-insured plans. This is made clear by the finding in the relatively recent U.S. Supreme Court case, Rutledge, which found that Arkansas had a state interest in regulating the prices paid by pharmacy benefit managers to pharmacies in order to protect access to pharmacy services in rural areas of that state. The Court found this was within the state's authority even if that regulation affected what self-insured plans paid in terms of pharmacy services. OHCA can reach the costs paid to hospitals and physician organizations by self-insured plans, without touching the costs or administration of the self-insured plans. About 30% of all California consumers with commercial coverage, 5.8 million of the 19.8 million Californians with commercial coverage are enrolled in self-insured plans[15], largely subject to ERISA[16]. Part of the goal of OHCA is to reach the costs of coverage for these Californian consumers as well.

Summary on Reporting by Market Segment

The proposed approach of tracking and enforcing compliance with the spending target by market segment for each payer and provider organization is consistent with the statutory authority and the policy that led to the development of OHCA. The target is then 3% for Medicare growth, 3% for Medi-Cal spending growth, and 3% for commercial growth so long as the statewide target is in effect. At the entity level, this would be adjusted for year over year changes in age and gender of the population served.

Entities Affected by the Target:
A Few Dozen Entities Provide or Pay for Most Care in the Commercial Market

At the March 2024 meeting, OHCA staff presented an estimate of the number of health plans, hospitals, and physician organizations required to comply with the statewide target, totaling more

[15] https://www.chcf.org/wp-content/uploads/2023/10/CAHealthInsurersEnrollmentAlmanac2023QRG.pdf
[16] Some self-insured plans serving public employees such as CalPERS and school VEBAs are subject to state law.

than 700 entities[17]. While OHCA must have a comprehensive view of the entire health system, we also think OHCA's work will be manageable because of the consolidation that has already occurred.

In short, when looking at commercial coverage, a relatively small number of entities in each category account for an overwhelming majority of consumers. Specifically,

- Three health plans account for 75% of commercial enrollment: Kaiser, Blue Shield and Elevance[18], covering 15.7 million of the 19.8 million California consumers in commercial coverage both state-regulated and self-insured.
- Ten physician organizations aligned, controlled or affiliated with ten large health systems accounted for 80% of the estimated 75,0000 practicing physicians in 2018[19], a share that has grown since then.
- Similarly, depending on the geographic region, a handful of hospital systems often dominate commercial coverage:
    - In Oakland/Berkeley, it is Kaiser and Sutter.
    - In Sacramento, it is Dignity, Kaiser, Sutter and UC Davis.
    - In San Diego, it is Kaiser, Scripps, Sharp and UC San Diego.
    - In Monterey, three hospitals dominate while in Santa Barbara, only a single hospital system provides care.
    - Los Angeles at first glance looks as if there is more competition but when looked at by sub-markets, similar market dominance is common.

Looking at a relatively small number of health plans and health systems, perhaps two dozen or so entities, should allow OHCA to determine whether change is happening in a meaningful way.

Health Access does not suggest that OHCA abandon its charge to be comprehensive in its oversight of health care costs. It is important that OHCA also look at the individual entities to determine compliance: part of the motivation to create OHCA was a recognition that a high-cost outlier could drive costs in a region or specialty and a recognition that high-cost outliers could become market trends if other entities shadow-priced off the high-cost outlier. We merely suggest that looking at the 20-25 health plans and health systems that finance or provide the overwhelming majority of care received by California consumers with commercial coverage helps to focus OHCA's efforts in a manageable way.

Because of consolidation and the current market realities, we reject the argument that an aggressive target will mean OHCA will be burdened with a review and performance improvement process for hundreds of entities. Performance improvement of a handful of big entities, especially those that have the largest cost increases, can have a big impact on the market as a whole.

One Year Target: Functional Delay of Years: Oppose

Health Access opposes a one-year target because it functionally delays enforcing the target for years. Why is a one-year target functionally a delay in enforcing the target? Data on performance on the target for the year 2025 will not be reported until 2027 at the earliest and action to revise the

[17] Slide 26 https://hcai.ca.gov/wp-content/uploads/2024/03/March-2024-Board-Meeting-Presentation.pdf
[18] https://www.chcf.org/wp-content/uploads/2023/10/CAHealthInsurersEnrollmentAlmanac2023QRG.pdf
[19] https://www.chcf.org/wp-content/uploads/2022/02/CAPhysicianPracticeLandscapeRapidlyChanging.pdf

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

target could linger into early 2028, meaning that no additional target would be set until the target for the year 2029.

What do those who propose a one-year target for 2025 suggest we do for 2026, 2027, and 2028? Twiddle our thumbs while costs spike once again? No. Health Access opposes a one-year target and supports the proposed five-year target.

We also note that contracts between payers and providers are routinely three-year contracts: it takes time to adjust these contracts. A one-year target ignores that practical reality. Industry stakeholders need a multi-year goal in order for it to make sense for them to make the needed system and contract changes, investments, and innovations.

Summary

We continue to support the 3% target, with a recognition that change takes time to implement.

Thank you for your consideration and leadership in this crucial effort to provide relief and value for California patients and the public.

Sincerely,

Beth Capell, Ph.D.
Policy Consultant

Anthony Wright
Executive Director

CC:

Senator Mike McGuire, Senate President Pro Tempore
Assemblymember Mia Bonta, Assembly Health Committee Chair
Senator Richard Roth, Senate Health Committee Chair
Assemblymember Akilah Weber, M.D., Budget Subcommittee on Health Chair
Senator Caroline Menjivar, Senate Budget Subcommittee on Health and Human Services Chair
Michelle Baass, Director, Health Care Services Department
Mary Watanabe, Director, Department of Managed Health Care

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

Appendix

We have reviewed the comments on the proposed spending target filed as March 11, 2024. We find that some comments suffer problems with methodology, selective use of data or a misunderstanding of the timing or impact of the proposed spending growth targets. In the best academic tradition, we offer observations on those comments.

Methodology Problems, Selective Data, and Timing Misunderstood

Inflation Estimates Overestimated by Some

Several commenters point to the level of inflation in recent years. The use of equally reliable estimates of expected inflation produces a quite different target closer to 4%. Substituting the estimates of inflation from either the Department of Finance or Congressional Budget Office lower the estimated rate of inflation from 3.3% or 3.4% to 2.4% or 2.6% (using 2024-2028, the years available) and perhaps even lower for 2025-2029, given inflation trend.

Aging

We reject the use of aging as a factor to adjust the statewide target for two reasons:

- First, the cost of the over-age-65 population is borne almost entirely by Medicare, not by commercial coverage. Even for those on both Medi-Cal and Medicare, Medicare bears the brunt of the health care cost increases. As noted earlier, Medicare has its own system of providing rate increases, not subject to control by the Office.
- Second, using aging in the statewide target as well as an adjustment to entity-specific targets partially double-counts this factor. Given how large aging looms in the minds of some commenters, perhaps they intend to double-count it but doing so seems methodologically dubious.

Net Patient Revenue versus Hospital Attribution

The Office has not, to the best of our knowledge, proposed use of net patient revenue as a measure of growth in spending. If they did, we would oppose it because it fails to reflect total revenue received by hospitals or health systems. Total revenue for many hospitals includes substantial revenues received from other sources, such as rental income or investment income[20]. A comprehensive look at revenue for health systems, information which HCAI does not collect at this time, would reflect revenue up-streamed to systems and used for expansion, central administration, or other purposes.

In the January 2024 meeting, the OHCA staff explored two different, possible methods of attributing costs to hospitals, neither of which relied on net patient revenue.

Medicare Economic Index
Health Access supports tracking performance against Medicare because Medicare can serve as a benchmark for an efficiently run health system. Paying 100% of Medicare or something close to it is

[20] CHCF

a reasonable place to start in terms of basing costs on the actual cost of providing care. Use of the Medicare Economic Index should only be considered if the base of spending is the Medicare rate, not inflated commercial prices.

The Medicare Economic Index to inflate commercial prices has other flaws:

- As we understand it, the Medicare Economic Index (MEI) reflects the cost to run the office of an individual physician, yet the OHCA law applies to large physician organizations with 25 or more doctors, not an individual doctor. Some of these physician organizations include thousands of physicians or even more than ten thousand physicians[21]. Surely a measure that might be appropriate for an individual physician does not capture the economies of scale of a larger organization.
- Looking at the prior ten years or twenty years of MEI produces an average increase closer to 3%. As studies that review various other factors reveal, use of data for a single year introduces considerable volatility, which is undesirable in terms of planning for change.

Experience of Other States

We appreciate the ongoing efforts of OHCA staff to report accurately on the targets selected by other states and the evolution in those targets over time, including this year. We do not appreciate the reliance of some on outdated and selective use of data on targets in other states.

Medi-Cal Improvements: Timing Matters

Several commenters point to various Medi-Cal improvements but often without accounting for the timing of those improvements:

- The final Health4All expansion of Medi-Cal to the undocumented occurred in January 2024 and thus this will be built into the base of spending for the 2025 target and beyond.
    - Further, the target is measured on a per capita basis and the per member per month spend for the Health4All population is the same as for other Californians in the relevant aid category (children, seniors, parents, "childless" adults without children under 18 at home).
- With respect to the MCO rate enhancements, most of those are taking effect in 2024[22].
    - One commenter raised a concern about the long tail on payment of Medi-Cal improvements compared to the 18-month tail permitted for claims to be reconciled. This is easily resolved since the state Medicaid agency, DHCS, will track when payments are made and can provide that information to OHCA.

Prescription Drugs, Technology: Revenue Generators

Importantly for the work of OHCA in controlling costs while improving outcomes, many of those who raise the cost of prescription drugs as a factor in health care costs fail to acknowledge that high-cost prescription drugs, particularly those administered in health facilities or by health professionals in other health care settings, are revenue ***generators*** for those facilities and professionals who often get paid a percentage of drug costs. These costs are buried in claims for hospitals, inpatient and

[21] Yegian and Green
[22] https://lao.ca.gov/Publications/Report/4838#MCO_Tax.2011Funded_Provider_Payment_Increases

outpatient, and physician care, not separated out like outpatient prescription drug costs which are identified in the SB 17 reporting. While current reporting does not separate out these costs, various academic articles have attempted to do so. For example, a recent piece compared drug prices, hospital costs and the impact of the 340B program on hospital revenues.[23] The article found:

> In some important cases, however, hospitals are able to translate high input prices into even higher output prices, creating a revenue stream and contribution to profits from what otherwise would be a cost stream and reduction in profits. This is especially the case for infused drugs for cancer, auto-immune disease, and other complex conditions…
>
> This is not a financially neutral process. Hospitals charge reimbursement prices to insurers in excess of the acquisition prices they pay to manufacturers, retaining the difference as revenue. Additionally, hospital facilities eligible for the federal 340(B) program obtain reductions in the acquisition prices they pay to drug manufacturers.

Second, prescription drug prices do decline as well as increase:

- Today 80% of prescription drugs prescribed outpatient in California are generic drugs (verify, cite SB17).
- Sovaldi, initially the poster child for high drug costs when it was introduced at a whopping $86,000 now sells for ???, still a significant sum but far less.
- Similarly, the new weight loss drugs are expected to drop in price as more come on the market and some become generic. U.S. Senator Bernie Sanders thinks it could be manufactured for $1 (one dollar) per month.
- Insulin, a focus of debate over drug prices, is dropping in price as some manufacturers reduce prices and as California moves to manufacture its own insulin through CalRx.

[23] https://www.healthaffairs.org/content/forefront/hospitals-drug-price-markups-incentivize-consolidation-and-reduce-funding

California Hospital Association

April 19, 2024

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

Subject: **Comments on the March 2024 Health Care Affordability Board and Advisory Committee Meetings**
(Submitted via Email to Megan Brubaker)

Millions of Californians each year rely on hospitals for life-changing, life-saving care. California's hospitals recognize that accessible, affordable care is out of reach for too many patients and stand ready to work with the Office of Health Care Affordability (OHCA) and other stakeholders to transform our health care system into one that best serves patients. To this end, and on behalf of more than 400 hospitals and health systems, the California Hospital Association (CHA) is grateful for the opportunity to comment on OHCA's March Health Care Affordability Board and Advisory Committee meetings.

Modifications to the Proposed Spending Target Are Essential

Proposal Would Set Up Health Care Payers and Providers to Fail. A credible target is an achievable target that reflects the need to improve affordability for all Californians and the actual costs of providing essential health care services — not a false promise that commits to spending levels that economic, demographic, and public policy trends all show would be unattainable. A credible target must be one that payers and providers both recognize in their negotiations and strategic planning as an achievable goal — not one that condemns all payers and providers to failure.

Unfortunately, OHCA staff's proposed 3% spending target ignores this precept. As has occurred in most other states, California health care spending is almost certain to blow past the target, raising doubts among health care entities and the public about OHCA's efficacy while subjecting hundreds of health care entities to an opaque enforcement process that lacks any clear standards.

Fortunately, there is time to fix these deficiencies. Hospitals encourage the board to consider the adjustments summarized in the "Framework for a

Framework for a Sustainable Spending Target

	2025	Average 2025 - 2029
1) Economy-Wide Inflation	**3.3%**	**3.4%**
2) Aging	**0.8%**	**0.7%**
3) Technology and Labor:	**0.6%**	**0.6%**
A) Drug and Medical Supplies	0.4%	0.4%
B) Labor Intensity	0.2%	0.2%
4) Major Policy Impacts:	**1.6%**	**0.6%**
A) Health Care Worker Minimum Wage	0.4%	0.2%
B) Investments in Medi-Cal	1.1%	0.3%
C) Seismic Compliance	0.1%	0.1%
Totals	**6.3%**	**5.3%**

Sustainable Spending Target," proposed in CHA's March 8 letter. These adjustments would place the spending target on a more attainable, sustainable, and credible path.

OHCA Should Adopt Two Board Member-Proposed Modifications. In March, OHCA board members proposed two reasonable modifications to the proposed spending target, which CHA encourages the board to adopt:

- A demographic adjustment aimed at protecting access to care for California's growing aging population
- A glide path to prevent shocks to the system and promote longer-term affordability and access, not the indiscriminate slashing of costs

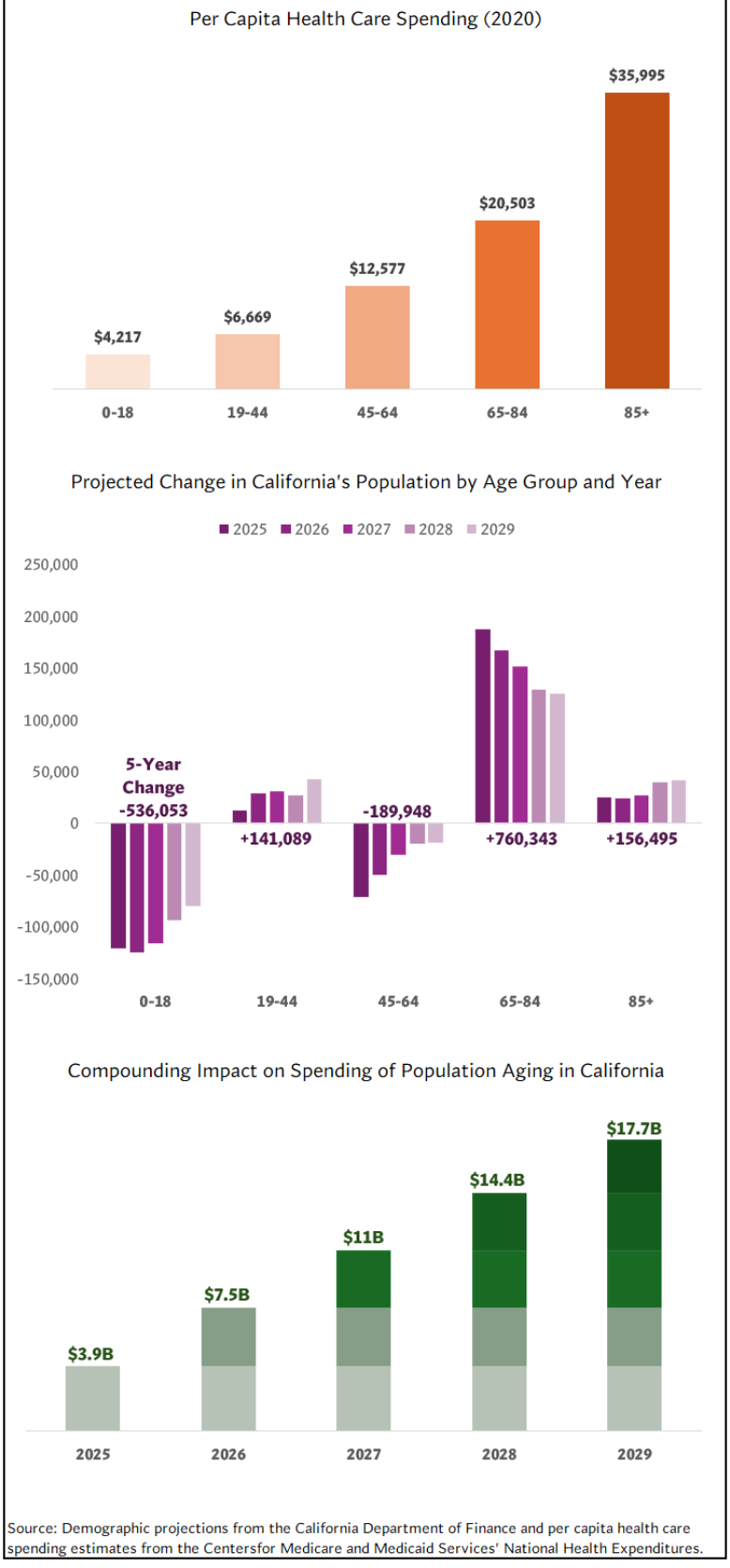
A Demographic Adjustment Is Essential. The figure on the right shows three trends that cannot be ignored:

- Health care spending on seniors is nearly 10 times that for children and youth.
- California's 65+ population is projected to grow by over 900,000 over the next five years.
- These two factors will raise health care spending by nearly $18 billion (3.5%) over 5 years.

The proposed spending target focuses solely on household earnings, entirely failing to acknowledge the growing health needs of this vulnerable population.

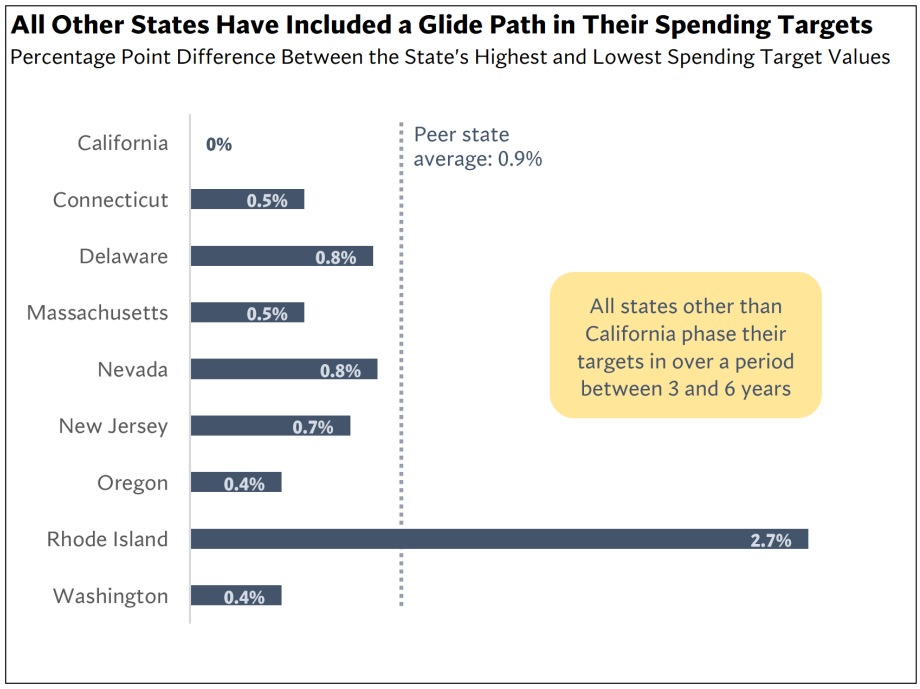
Population aging will increase the need for health care services due to growth in chronic disease and cancer prevalence. Between 2024 and 2029, 2 million additional Americans are projected to be diagnosed with cancer, a roughly 10% increase in just five years. According to the National Institutes of Health, cancer treatment costs over $150,000 per

Aging Is Expected to Increase Health Care Spending in California by Nearly $18 Billion Between 2024 and 2029



Source: Demographic projections from the California Department of Finance and per capita health care spending estimates from the Centersfor Medicare and Medicaid Services' National Health Expenditures.

patient, more than 10 times that of general health care spending for the population as a whole. Unless unduly rationed, treatment for these additional cancer patients, and other aging Californians with growing health needs, would save millions of lives and come at a real — but entirely worthwhile — cost.



Adding an aging adjustment would acknowledge the growing needs of California's aging population and place the target on a more sustainable path. While CHA believes a 0.7-0.8% adjustment would more accurately capture the anticipated impact of aging, hospitals support the inclusion of a 0.5% adjustment and urge the board to adopt this essential change.

A Glide Path Would Protect Against Sudden Reductions in Access and Quality. OHCA's fundamental responsibility is to improve value without sacrificing access to, or the quality of, health care. This cannot be achieved overnight. Nevertheless, the current proposal would mandate, in a single year, a 40% reduction in spending growth. Such a radical change in the long-term trajectory of health care spending growth cannot be achieved without drastic measures that would have serious, negative consequences for patients, such as service line reductions; decreased investment in technology, workforce, and other critical needs; and slower innovation.

In stark contrast, raising the value proposition of health care depends upon delivering the right care, at the right time, and in the right place. It means preventing disease before acute care is needed, including through expanded access to primary care and behavioral health services.

Achieving OHCA's underlying vision will require more investment at the outset, not immediate caps on spending that do not even keep up with general inflation. The benefits of improvements like expanded primary care can only be realized gradually, meaning divestment now will only make the transition to better care more difficult and fraught with unnecessary patient suffering.

A glide path also would recognize the state's current efforts to increase equitable access to care and address health care workforce challenges, such as to expand Medi-Cal access or raise minimum wages for health care workers. These two policy changes alone, combined with other cost pressures, would make it impossible for the vast majority of health care entities to meet a 3% spending target starting as soon as next year. Accordingly, a glide path would move the spending target in the right direction by making it more realistic, attainable, and credible.

Every Other State Spending Target Program Includes a Glide Path. Every other state with a similar program has recognized the need to facilitate a planned transition to a lower spending growth environment, rather encourage a mad dash to lower spending at the expense of patient care. As such, every other state has phased its target down over time. On average, the eight other states started with

(or adjusted to) targets that initially are about 1 percentage point higher than their final targets, phasing them in gradually over three to six years. The figure on the right shows the difference between the other states' highest and lowest targets, showing by how much they phased their targets in over time. *(See appendix 1 for more detail on each state's glide path and how states have performed against their spending targets to date.)*

OHCA Board Must Adopt a Meaningful Glide Path. With the aim of ensuring attainability, preventing sudden deterioration in access and quality, and incorporating lessons from other states, the board should adopt a glide path that gradually reduces the spending target over five years. Based on other states' experience, starting about 1 percentage point above the final target value would be appropriate.

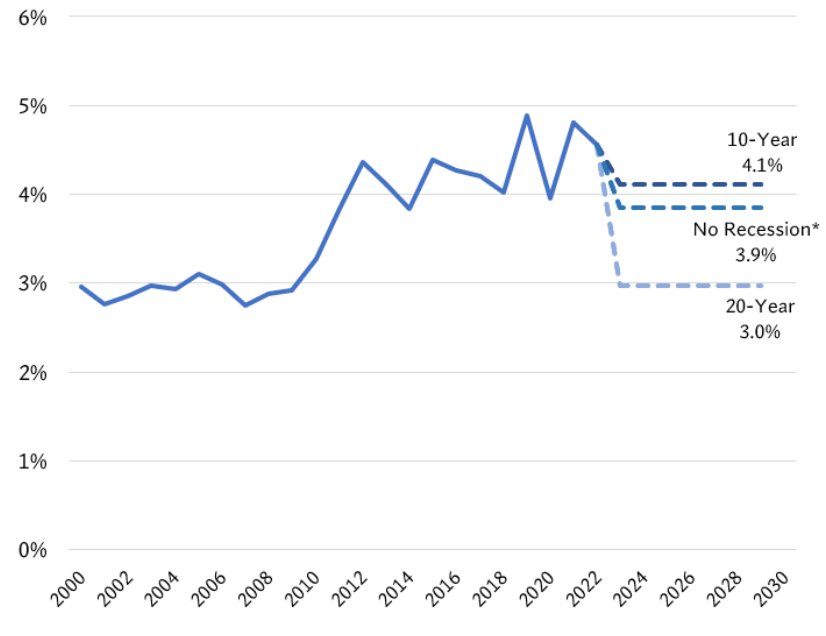
Proposed Spending Target Methodology Continues to Contain Major Flaws

CHA's March 8 letter revealed several significant flaws with the proposed spending target methodology and value, including to the use of a 20-year lookback at household income growth and additional ways in which OHCA's proposed target is an outlier compared to other states. These flaws must be addressed before a target is finalized.

Using a 20-Year Lookback for Household Income Growth Mistakenly Assumes a Massive Drop in Growth Going Forward. OHCA's stated rationale is that health care spending should not grow faster than household income. However, OHCA's estimate of household income growth is biased by using old data that includes the worst recession in a century. As the figure on the right shows, OHCA's estimate effectively assumes a more than 25% drop in household income growth compared to the last decade's trend. This is driven by the inclusion of the Great Recession period between 2009 and 2011, when growth was negative. The Great Recession was, by definition, an outlier event. Economists and professional forecasters, when analyzing trends over time, generally exclude outlier events from their projections, effectively assuming events that occur once in a hundred years will not occur again in the next several years. In addition to showing how a 10-year average is more reasonable than a 20-year average, the graph above shows that using a 20-year trajectory that removes the outlier years results in a multiyear average of 3.9%. Moreover, this methodology has limited volatility and has been more predictively accurate of

Using a 20-Year Average of Household Income Growth Assumes a 25% Drop in Growth Compared to the Last Decade of Trends

Average Annual Percent Change Starting in the Year Displayed, Ending in 2022, or Projected Through 2029



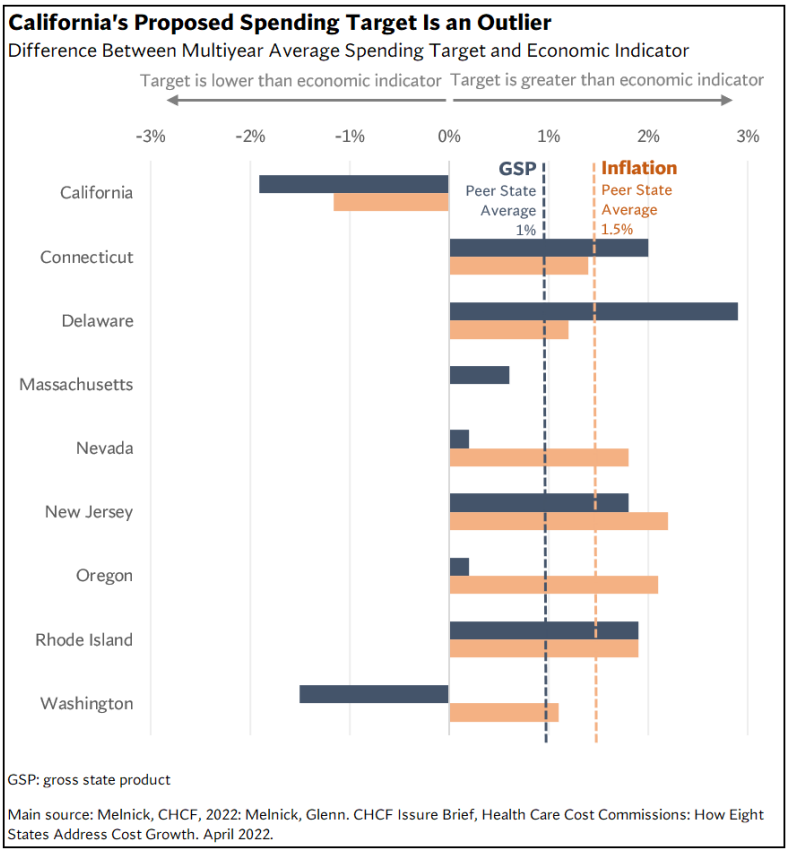
* "No Recession" is a 20-year projection that excludes the Great Recession-era growth rates from 2009 through 2011, a treatment for outlier events that is common in time-series econometrics.

Note: 2019 median income adjusted downward by 2.8% to reflect OHCA staff's finding that income may have been overestimated that year by the Census Bureau.

Source: California median household income data retrieved from FRED.

household income growth than other approaches. The board should consider modifying the proposed household income methodology to remove the effect of the Great Recession.

OHCA's Proposal Is Inconsistent with Other States' Approaches. OHCA's proposed target is the most aggressive in the nation, and not just because it fails to include a glide path. Only one other state has set a health care spending target that is less than its historical economic growth: Washington, which has a nonbinding target. On average, other states set their targets to be about 1 percentage point **higher** than their recent historical economic growth. In contrast, OHCA has proposed a target that is nearly 2 percentage points lower than California's recent economic growth. The same holds true for inflation: all other states set their targets higher than recent historical inflation (1.5 percentage points above, on average). OHCA's proposed target is more than 1 percentage point less than recent inflation. The figure on the left illustrates just how much of an outlier California's spending target would be in relation to other states on these two key economic indicators. No justification has been given for why California's target should stand alone in these critical respects.



Inflation Ticking Up, Not Down. Health care spending is driven by broader economic conditions, like inflation and economic growth. And yet, the proposed spending target ignores the primary economic trend of the last two years: sky-high inflation that is proving anything but transitory. While inflation averaged less than 2% in the year leading up to when other states set their spending targets (averaging 3.3%), inflation came in at over 4% in the year leading up to California setting its target. Despite moderation toward the end of 2022 that led to hopes that it would return to its targeted level of 2%, high inflation has not only persisted, but, in fact, grown worse, prompting the Federal Reserve to signal that interest rate cuts will be delayed to later in the year at the earliest. As of March, short-term inflation stands at an annual rate of 4.6% (more than 50% higher than the proposed spending target). Moreover, inflation is concentrated almost entirely

within the service sector — which includes most of the health care sector. The OHCA board must recognize that the spending target is being set in economic conditions that did not apply when other states set their target, and that an adjustment is needed if the target is not to be ignored due to being wholly disconnected from the cost of patient care.

Integrated Healthcare Association (IHA) Data Do Not Demonstrate That a 3% Target Is Achievable. At the March board meeting, OHCA presented publicly reported total cost of care data from IHA in an effort to demonstrate that its spending target is achievable. OHCA's contention was that growth of 3% among reporting health maintenance organizations (HMO) between 2017 and 2021 showed that 3% spending growth is an attainable goal. However, while the IHA data represent an invaluable source of information on health care spending and quality, CHA understands that the publicly reported data used by OHCA excluded certain high-cost patients' spending growth from the dataset, resulting in understated spending growth in the HMO line of business. Once revised, we understand that IHA estimates growth over this period was closer in line with the 5% annual growth in health care spending that California and the nation have experienced over the long term.

Further questions abound related to whether these data justify the OHCA staff proposal. First, using a historical series of spending growth that ends in 2021, the middle of the COVID-19 pandemic, undoubtedly biases the resulting growth figures unless artificially corrected. Second, while the spending data are risk-adjusted, this risk adjustment does not eliminate the systemic difference in the risk profiles of HMO versus preferred provider organization (PPO) members. Despite an apparent anomaly in the 2021 public data, these data otherwise make clear that PPO members have higher health needs than those in HMOs, driving higher growth in this insurance product type.

Cost-Reducing Strategies Hold Promise, But Will Take Time to Bear Fruit. OHCA has sought to learn from health care entities about strategies to bend the cost curve and improve the value of California's health care system. To date, one health plan and two health systems have presented to the board their successful strategies. Health systems emphasized investments in integrated, whole-person care with aligned value-based financing arrangements as fundamental drivers of success. At the same time, they acknowledged that the widespread penetration of the HMO model in California means that future opportunities to generate savings from expanding this care model are more limited in California than elsewhere. Further, CHA has presented opportunities to improve the value of patient care, such as improving the care transition process so that patients can move to lower levels of care as soon as their conditions permit, streamlining utilization management and payment processes that divert time and resources from clinical care, and other policies that promote whole-person, integrated care.

While there are known and promising opportunities to improve the value of care, the realizable savings that can be generated by implementing new policies and strategies is uncertain, unlikely to materialize quickly, and smaller than the roughly 10% cut in health care spending that a 3% spending target would impose compared to longstanding growth trends over a five-year period.

Medi-Cal and Medicare Payers and Providers Must Be Subject to Consistent Enforcement Standards

In March, OHCA staff presented its intent to provide a blanket exemption from enforcement against the spending target for payers for growth in their Medi-Cal and Medicare lines of business. As justification, staff cited the fact that public payer spending is regulated by other state and federal agencies. However, OHCA does not propose to extend this blanket exemption to providers. Instead, staff declared an intent to determine whether to enforce spending against the target within providers' public lines of business on a case-by-case basis.

The proposed inequitable treatment of payers versus providers has no justification. In Medi-Cal, the Department of Health Care Services (DHCS) reviews historical pricing and utilization data coming from plans that are equally constitutive of what is paid to providers. DHCS and its actuaries ultimately certify the reasonableness of these reported pricing and utilization levels, with adjustments to account for trends, policy changes, and other factors. For these purposes, the spending data going into the DHCS review are simply two sides of the same coin for payers and providers.

The following example illustrates the incoherence of the proposed approach. Imagine that DHCS certifies a year-over-year capitated rate increase of 5% to protect and promote access in Medi-Cal. Unless plans were to keep the entire increment of the capitated rate increase above, for example, a 3% spending target for their own administrative functions and profit, their providers' year-over-year revenue growth would be above the spending target. Punishing providers for "excess" growth would disregard DHCS' decision to raise capitated rates above the target and create a double standard where providers, but not payers, could be punished by one regulatory body (OHCA) for decisions made by another (DHCS). To prevent such a circumstance, OHCA should treat providers according to the same standard it proposes for payers, rather than subjecting them to enforcement against the target for spending in public programs.

OHCA's Approach on Workforce Stability Is Reasonable; Including Physicians Would Make the Effort Even More Comprehensive

In March, OHCA unveiled a comprehensive and workable approach to measuring workforce stability. The proposed approach appropriately aims to not only look at performance at the individual entity level, but at the statewide and geographic levels as well as a means of identifying and helping policymakers address systemic workforce challenges impeding access to affordable care. The approach relies on existing, extensive reporting by health care entities and other organizations, rather than imposing new burdens. It recognizes both the learning that the office must do in this novel effort and the distinct ways that health care entities track and promote their performance on workforce development.

One change should be considered. As multiple OHCA advisory committee members noted, the proposed approach forgoes a promising opportunity for OHCA to comprehensively assess health care workforce stability. Specifically, OHCA has declared an intent to not include the physician workforce in its analyses. Given the extent of primary care and other physician shortages and the resulting access barriers, as well as the opportunity to be a comprehensive source of information on the health care workforce, OHCA should include this set of professionals in its work.

Increased Focus on Health Plan Profits and Practices is Essential

OHCA's success will depend wholly on whether payers translate lower growth in medical expenditures into lower premiums and cost-sharing requirements. To date, OHCA has paid scant attention to the practices of health plans that have impacted — and will continue to impact — Californians' ability to afford health care. Increased scrutiny of the practices and finances of the state's $240 billion health plan industry is essential for progress on OHCA's mission. Below are just a few of the ways health plans drive affordability problems and the steps OHCA can take to address them:

- **Special Oversight of Health Plan and Insurer Premiums Is Needed.** OHCA's work will be to no avail unless health plans and insurers translate the savings from constrained growth in health care spending to lower premiums and cost-sharing requirements. Accordingly, OHCA must incorporate into its analysis data on premium spending and out-of-pocket costs. While OHCA has proposed using the Medical Expenditure Panel Survey to assess the latter, no attention has been paid to the former. Fortunately, data are readily available on premiums since health plans and insurers currently report this information to state regulators. OHCA should gather this premium

data and report on how premium growth compares to OHCA's own measures of health care spending growth. This will be essential for actually holding payers accountable under the spending target and evaluating whether OHCA is achieving its stated goal.

- **Spending Target Must Apply to Health Plan and Insurers' Administrative Spending and Profits.** Within the next two months, OHCA will establish the first statewide spending target. This will apply to all health care entities, including payers. Paragraph (h)(1) of Health and Safety Code Section 127502 requires that *"Targets set for payers shall also include targets on administrative costs and profits."* Despite this clear statutory requirement that spending targets applicable to payers explicitly extend to their administrative costs and profits, OHCA has not proposed how it will do so. At an upcoming board meeting, OHCA should present on how specifically it intends to fulfill this critically important provision in law that aims to prevent health plans and insurers from profiting while at the same time limiting access to care for their members.
- **Severe Lack of Competition.** Just three health plans control over 75% of the commercial market, meaning premium purchasers have almost nowhere to turn to obtain better rates and benefits. This troubling lack of competition allows health plans to collect outsized profits without providing real value to their members. OHCA should use its substantial resources and analytical capacity to shed light on the limited choices health care consumers have when selecting coverage and encourage meaningful competition.
- **Vertical Consolidation.** When health plans pay for care, they often are simply paying their own subsidiaries. This is because health plans increasingly own or are affiliated with the medical groups, pharmacy benefit managers, and other intermediaries through which their members must access care. What's more, patients' options are regularly limited via steering by plans to affiliated providers. As with the overall lack of competition among health plans, OHCA should use its authority to investigate vertical integration among health plans and their affiliates and the negative consequences for affordability and patient care.
- **Benefit Design.** Previous OHCA board meetings have featured compelling data and stories of the impact high out-of-pocket costs have on patients' financial well-being, willingness to seek care, and perceptions of health care affordability. High out-of-pocket expenditures stem from two conditions: uninsurance and underinsurance. While the state has made remarkable progress lowering the uninsured rate, addressing underinsurance has proven far more challenging. The reason is excessive marketing of high-deductible, narrow network products by health plans, which effectively transfer payment responsibility to patients at the point of care. OHCA should scrutinize these products for the negative impacts they are having on consumer affordability and identify and promote policy innovations that can increase enrollment in comprehensive, low cost-sharing products, such as those available through Covered California.

Conclusion

OHCA must plan for the health care system Californians need and deserve. It is imperative that the state address affordability challenges while at the same time meaningfully and measurably improving access to high-quality, equitable, and innovative care. CHA is committed to helping the office develop a thoughtful, data-driven approach to achieving its multiple objectives. We are grateful for the opportunity to comment and look forward to continuing to work closely with OHCA staff and its board to craft policies that address affordability challenges while protecting access to health care.

Sincerely,

Ben Johnson
Vice President, Policy

cc: Elizabeth Landsberg, Director, Department of Health Care Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability
Members of the Health Care Affordability Board:
David M. Carlisle, MD, PhD
Secretary Dr. Mark Ghaly
Dr. Sandra Hernández
Dr. Richard Kronick
Ian Lewis
Elizabeth Mitchell
Donald B. Moulds, Ph.D.
Dr. Richard Pan

Appendix 1


Under the Current Proposal, California Would Be the Only State Not to Include a Glide Path
Growth Target
Performance
Connecticut
6.1%
3.4%
3.2%
2.9%
4.0%
2.9%
2021 2022 2023 2024 2025
Delaware
11.2%
5.8%
3.8%
3.5%
3.3%
3.0%
-1.2%
2019 2020 2021 2022 2023 2024
Massachusetts
9.0%
4.8%
4.2%
3.0%
3.6%
4.1%
2.4%
3.6%
2.8%
3.1%
3.6%
-2.4%
2013 2015 2017 2019 2021 2023 2025
Nevada
3.2%
3.0%
2.8%
2.6%
2.4%
2022 2023 2024 2025 2026
New Jersey
3.5%
3.2%
3.0%
2.8%
2023 2024 2025 2026 2027
Oregon
3.5%
3.4%
3.0%
2021 2022 2023 2024 2025 2026 2027
Rhode Island
6.0%
5.1%
4.1%
3.2%
3.2%
3.6%
3.3%
-2.9%
2019 2020 2021 2022 2023 2024 2025 2026 2027
Washington
3.2%
3.0%
2.8%
2022 2023 2024 2025 2026
California
3.0%
2025 2026 2027 2028 2029