CHA Summary of the Dec. 19 Health Care Affordability Board Meeting

The Office of Health Care Affordability (OHCA) is overseen by the Health Care Affordability Board, which held its 8th and final meeting of 2023 on Dec. 19. The meeting touched on four topics:

- The Health Care Affordability Advisory Committee (re)appointment process
- The finalization of the cost and market impact review (CMIR) regulations
- The proposed total health care expenditure (THCE) data collection process
- OHCA staff's preliminary proposal for spending target value and model.

Additionally, Chair Mark Ghaly proposed that the board do future meetings in other regions of the state, notably in Monterrey County to learn more about issues there.

Advisory Committee (Re)Appointments. The Health Care Affordability Advisory Committee meets at least quarterly and provides feedback and advice on matters under consideration by OHCA. Unlike the board, the advisory committee does not decide matters before OHCA. The advisory committee currently has 27 members representing a variety of perspectives, including payers, providers, organized labor, purchasers, and consumer advocates. Advisory committee members are normally appointed for two-year terms. However, the terms for half of the current members expire after one year, meaning they expire in June 2024.

At the Dec. 19 meeting, the board decided on a process for (re)appointing members to the advisory committee. As previously, the board elected to create a subcommittee to make recommendations on (re)appointments, and selected Richard Pan and Elizabeth Mitchell to again serve on this subcommittee. Solicitation of applications will occur from January to March, selection will occur between March and May, and the first meeting for new members will occur in September. Multiple board members expressed an interest in continuity to the extent existing advisory committee members are willing to serve additional terms.

CMIR Regulations. OHCA staff presented an overview of the final CMIR regulations, which became effective on Dec. 18 after clearing the review process from the Office of Administrative Law. The final version of the regulations included a number of changes from the most recent proposed, Nov. 28 version. While most changes were technical, the key substantive changes included:

- The definition of a health care entity now only includes parents, affiliates, or subsidiaries that act on behalf of a payer, no longer including such entities that act on behalf of providers.
- Previously, entities located in a mental health or primary care health professional shortage area had to file notices for material transactions regardless of their size in terms of revenues or assets. This was amended to only include entities located in a primary care shortage area.
- For determining whether a transaction is "material," "changes in control" were redefined to no longer include transactions resulting in a transfer of 25% or more of the governance of the management and policies of a health care entity that is party to a transaction. This updated definition now only includes transactions resulting in a transfer

of 25% or more of the voting power of a governing body, including through changes in voting power not due to substitutions of board membership.
- The ability of a health care entity to meet its spending target was removed as criteria for OHCA to determine whether to conduct full CMIR and factor to consider in a CMIR report.

During the subsequent discussion, Richard Pan reiterated his prior request for OHCA to publish performance metrics on the CMIR process. OHCA staff shared they would have access to this information but stopped short of committing to publishing it.

THCE Data Collection. OHCA staff provided an overview of the proposed THCE data collection regulations and supplementary guidance, as well as the public comments received. Public comments focused on patient attribution, the lack of clinical risk adjustment, issues with the claims run-out period, and the incorporation of data not being collected from health plans and insurers. OHCA staff committed to responding to public comments in January 2024.

Board members expressed concerns about the lack of data on providers' administrative costs. These comments stemmed from, on the one hand, concerns that some spending tracked as medical expenditures instead reflect administrative spending and profits and, on the other hand, concerns that administrative costs are increasingly being passed from payers to providers. OHCA staff committed to taking this back for further consideration.

Board members also aired concerns that out-of-pocket spending will not be tracked comprehensively, that patient liability and medical debt information is available from hospitals but not from medical groups, and that PPO and HMO attributed spending data should be distinguished.

Spending Targets. OHCA staff presented its preliminary recommendation for a statewide health care spending target value and methodology, as well as related considerations. OHCA staff specifically recommended an annual target of 3% for the years 2025 through 2029. OHCA arrived at this value by taking a weighted average of the last 20 years (through 2021) of growth in median household income in California. Median household income was chosen to tie the target to a measure of consumer affordability. The methodology placed marginally higher weight on the most recent 10 years compared to the prior 10 years. OHCA staff recommended against any adjustments, including to account for higher inflation, labor expenses, demographic changes (such as aging), health care technology cost growth, or to phase the target in over time.

The preliminary proposal, which will potentially be revised and updated on Jan. 15, sparked significant discussion among board members:

- Richard Pan and Richard Kronick questioned the use of a historical period for setting a spending target that includes two once-in-a-century events—the Great Recession and the COVID-19 pandemic. Pan asked for OHCA to update its period to use more recent available (2022) data, and to display what the target would be if based on different historical periods (five -year, 10-year, and 15-year lookbacks). Kronick suggested just looking at the last 10 years, thus removing the Great recession period.

- Ian Lewis objected to removing the Great Recession, and OHCA's consultant pushed back that 2019 data is (also) an outlier due to data collection issues (we note that this assertion appears mistaken).
- Elizabeth Mitchell expressed concerns that such a target would still allow for roughly 15% growth in health care spending over the five-year period.
- David Carlisle noted that the value of the target reflects a somewhat arbitrary decision, albeit one aimed at promoting affordability. He shared his belief that they were close to reaching a target. OHCA staff agreed that they are essentially just picking a number and that there is no perfect methodology.
- Mark Ghaly shared that more work should be done to get a greater handle on the justification for the chosen target, and that time should be taken to get it right. Pan agreed that a sounder rationale for the chosen target is needed and reiterated his concern that there is no adjustment to account for demographic changes, such as risk adjustment.
- Pan advocated in favor of adopting an adjustment to account for the price of health care technologies, while Kronick asked OHCA to look into indices that account for this factor. Kronick added that we don't want a health care system that looks like today's, and this factor should not be ignored when considering a spending target. Elizabeth Mitchell preferred looking at the cost of technologies in the enforcement process, rather than building an adjustment in at the front end (unless the adjustment is negative).
- Kronick and Pan requested an analysis of the health care labor market impacts of the spending target, including what jobs would be lost or not created.