HCAi Department of Health Care Access and Information
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Health Care Affordability Board
August 28, 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
08/28/2024	Anonymous	1. Is there any thoughts about using the States newest initiative PHM/ Medi-Cal Connect in order to derive more accurate health demographic data to help understand where the increased utilization trends/services. 2. Has anyone addresses the fact the SVMH and its systems have not renewed its contract with BlueCross/BlueShield? This has made a severe impact to those patient to find new providers and have come out of pocket to revive the needed services with outside network providers.
08/28/2024	Rikee Ross	My name is Rikee Ross. I am a teacher for MPUSD. I have taught at the same high school for my entire teaching career of 13 years. I started off as a long term substitute and completed my teaching credential in summer of 2014 when I signed my first official teaching contract with MPUSD. As I signed my contract I read about the medical plans available to families. At the time I was a single mother of 3 young daughters and to my surprise I could not afford the family plan that was offered. I put myself on the medical plan and had to enroll my daughters in Medi-cal because one it was free which was all I could afford at the time and two because due to my salary at the time I was income eligible for this program. Fast forward 13 years and now a mother of 4, still surviving on one income I am still unable to provide medical insurance through my district for my family. With a cost of almost $1800 a month. I am in medical debt due to an infection I had at the end of last year because the insurance only paid a portion of the bill. I am constantly having to juggle my

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		schedule because scheduling appointments for my children is extremely hard due to lack of appointment availability at the local medi-cal clinic. MY daughter who is in desperate need of therapy due to mental health issues is stuck on a waiting list because there are no therapists available offered through medi-cal. I am constantly in fear if my kids get super sick because that means I have to take a day or more off to get them appointments to be seen. My children;s health is a priority to me, but in some instances that means I am losing my sick leave in order to make sure they can be seen by an overburdened healthcare system that is supporting so many families in our community. Without private insurance I am left to take whatever appointments are offered. Which means instead of focusing on teaching some days I am worried about how I will get my children the medical attention they so desperately need. I am a public servant. I dedicate my life to other people's children but can't provide my own children with the health care they rightfully deserve. When comparing our medical rates with other districts in the area our medical costs are more than double, sometimes triple what other teachers are paying. There has to be a better solution to supporting our MPUSD families. Without medi-cal I would have had to leave the district a long time ago. As a teacher I shouldn't have to worry about my children's health. I shouldn't have to use my sick leave to get them the doctor's appointments they need. I shouldn't have to worry about my 13 year old daughter committing suicide because she can't get the mental health care that she so desperately needs. When will this change?
08/28/2024	Marielle Reataza	My name is Marielle Reataza, former physician and currently the executive director of the National Asian Pacific American Families Against Substance Abuse, based in Los Angeles County. I am also to start my tenure on the HCAI Advisory Committee in September. Thank you for this presentation and the thoroughness at which this data have been discussed. I echo the sentiments shared about the disparity between California utilization and spending on healthcare costs While our spending is sure to be influenced by the costs of living, I urge the Board to look into other factors that have been shown to both impact utilization and costs. I would like to better understand if the data can be disaggregated such

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		that we can better understand the following: length of wait to see PCP, payor costs disaggregated by payor type (private/consumer, public, employer-based), level of coverage (bronze tier subscribers often have coverage for emergencies but rarely access them due to high premium costs), specialty/subspecialty density across counties, and a list of most frequently used services/procedures, in comparison to the most costly services and procedures. Additionally, how much of these costs are impacted by delayed care? I would also like to better understand how much spending in CA is related to healthcare goods and services that do not fall under the purview of defined healthcare services. Lastly, I disagree that competition across healthcare is what allows for greater innovation. Competition in this manner is most relevant to technological and pharmaceutical advances that are rarely affordable or accessible for the most marginalized and often, economically-disadvantaged folks. This has been reflected in studies where high propensity of specific subspecialists are correlated with high referral rates and thereby, high procedural rates. Additionally, asserting that consumers have choice across these competitive providers is false. We know that geography, coverage, costs, health plan range, and provider density are hugely important in the selection of available providers, which limits this perceived notion of having “choice.” At the heart of the matter is this—we cannot treat healthcare as a commodity, nor as an industry meant to thrive in a competitive marketplace. Capitation is an economic term and not one that reflects the nuances of healthcare or what it means to be well. I urge us to stay away from this practice because in real-life situations, these theories simply do not apply. I appreciate the personal stories shared and HCAI’s commitment to improve access to healthcare while improving quality. I look forward to engaging further.
08/28/2024	Devra Dallman	Thank you for hosting the meeting 8/28/24 in Monterey. I appreciated the data presentations by Vishaal, CJ, Jessica and Don - informative. I was unable to make public comment and am submitting my comments now. Meeting feedback: Modify the agenda to reflect actual questions/answers among BOD members

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		between topics and to reflect the opportunity for public comment. The stories and passion demonstrated today was amazing - The worst driver of high health care expenditures in the US is profit. As mentioned earlier today insurance "earnings calls are shocking". The profit taking and making is not just draining our medicare trust fund at an accelerated rate, it's criminal with the lemon dropping, cherry picking and up-coding. Capping healthcare costs sounds wonderful, but one must understand where that leads. Cost = Price x Utilization. Cost is a function of Price x Utilization. Capping health care cost will push the risk to clinicians, not the insurers - clinicians already dealing with burn out and moral injury. If the for-profit middlemen are not investing in primary care and behavioral health today, what will incentivize them to invest with a 3% cap on what they can charge? So, who is it, exactly, that will invest in primary care and behavior health? The middlemen, insurance companies and private equity investors? No, they won't. Think about it, the middlemen don't do it today without the caps. Alternative Payment Models (APMs) are another deep topic. One of the assertions is that fee for service (FFS) payments are the problem causing health care cost increases. FFS is not the problem. The problem is excessive prices, huge administrative expenses, consolidation, entrance of private equity and for the profit taking middlemen. OCHAs documents reference that California APMs will be modeled after Accountable Care Organizations Realizing Equity Access Community Health (ACO REACH) and Medicare Shared Savings Programs (MSSPs). These are capitated programs that are fraught with fraud, demonstrate little or no cost savings and no improved outcomes. In fact, the California legislature voted to approve Assembly Joint Resolution 4 in 2023 to ask the Biden administration to halt ACO REACH programs in California. OCHA should NOT be using ACO REACH or MSSP as models for payment. We need single payer health care implemented - we need to stop the gouging and profit taking on the backs of working families and individuals.

Date	Name	Written Comment
		I encourage the OCHA team to model or pilot test risk adjustment factors, as Dr. Malinow recommended, to learn how risk adjustment will impact marginalized community access, equity and utilization. Addressing outliers and setting targets for Monterey seems appropriate, in addition to the cost market impact report (CMIR).
09/06/2024	Demetrius Kastros	My wife Linda and I are retired and as is the case with many other Americans, we have been dealing with the impacts of inflation in our economy. This week, we received a letter from my retirement system informing us that our PERS Platinum Medicare Supplement policy premiums are increasing by 30.47%. This increases our monthly out-of-pocket premium by $225 per month. This amount greatly exceeds the average increases for health care insurance recently published. It is extremely difficult for me to believe that the insurance company has experienced a 30% increase in their costs. This can only be interpreted as the company's belief that they can increase costs any way they wish because there's nothing preventing them from price gouging. I believe in the private enterprise system and normally am not a proponent of government regulation of our lives but medical insurance is a vital necessity, especially with retired seniors paying their own premiums. This is something California needs to examine closely as dramatic increases in medical insurance premiums seem to be occurring across a wide spectrum of California and all of America. Thank-you.
09/06/2024	Anthem Blue Cross	See Attachment #1.
09/10/2024	Bruce Hector	As a California senior resident and recently retired primary care provider to low and middle income patients, I have been trying to closely follow HCAI and it's challenging missions. I also regularly monitor some medical research in this field and noted 2 brief studies that pertain to 2 of OCHA's missions. I wish to refer the Commission to this revealing information in the recent issue of JAMA (Journal of the American Medical Association) Vol 332, Number 8, pages 601 - 682 from August 27,2024 noting 2 relevant studies.

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		The first article (pp 668 - 9), is related to access to mental health services by Medicaid patients (Medi-Cal in California) titled “Access to Psychiatric Appointments for Medicaid Enrollees in 4 Large US Cities” and included Los Angeles. It noted that just 17.8% of clinicians listed as “in-network” were “reachable, accepted Medicaid and could provide a new patient appointment.” Wait times even for these could be up to 6 months. It advised continued “secret shopper surveys” as a monitoring method. Does OCHA conduct these type of surveys? The second article is titled “Hospital Assets Before and After Private Equity Acquistion” (pp 669 - 70). It notes these firms spent $505 Billion from 2018 - 2023 on acquisitions. The study matched 10 acquired with 10 non-acquired hospitals by year, region, bed size and nearest neighbor. The discussion noted that after acquisition hospital assets decreased by 24% relative to controls during the subsequent 2 years. The study was compromised by limited size and lack of need to publicly report all hospital acquisitions. Does OCHA require hospital acquisition reporting in California? These studies reinforce the perception of grossly inadequate mental health services in our state, especially to Medi-Cal patients and demonstrate that despite promises of asset growth with private equity purchases, the opposite appears to be occurring implying that corporate takeovers result more in system depletion than growth. Mahalo for your attention to these issues.
09/10/2024	Unite Here Health	See Attachment #2.
09/11/2024	Judy Polli	I just today noted your recent hearing in our area and thought I might provide you with our recent experience with surgery charges incurred at Monterey Community Hospital (CHOMP). My wife had hernia surgery which was approximately 30 minutes in length. The total hospital charges was some $19493. Of this amount the drug charge was $10738 or some 50%. I requested an itemized detail and found one drug used was Sugammadex made by Merck. It is used to expedite recovery from anesthesia. It comes in standard 2 Ml Ampule. I researched wholesale cost to hospital range from $77 to $97 each. Based on my wife's weight one ampule would be sufficient to mitigate anesthesia whether heavy or moderate

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		anesthesia was employed. We were charged for 2 vials at $3294.00 each! I have appealed this charge to Federal OPM and Blue Cross Federal Insurance as being excessive and it is being investigated. We appreciate your comments. John and Judith Polli.
09/11/2024	American College of Obstetricians and Gynecologists	See Attachment #3.
09/24/2024	Health Access California	See Attachment #4.
10/04/2024	Katrina Hodges	I am concerned about the high costs that Montage is charging compared with other providers. In September, both my husband and I did regular labs. He used Bio Reference labs and I went to Montage Medical group labs. I was shocked when our bills arrived with wildly different price points. We had labs drawn within a week of each other in the same zip code. Code 85025 Bio Reference billed $37.39 and Montage billed $170 Code 80053 Bio Reference billed $50.82 and Montage billed $384 Code 80061 Bio Reference billed $64.44 and Montage billed $179 Code 84443 Bio Reference billed $80.85 and Montage billed $250 Since we have a high deductible Covered California plan, I was hit with a huge bill after Blue Shield had paid way more to Montage than they paid to Bio Reference. Montage needs regulation to control their inflated prices!
10/09/2024	California Hospital Association	See Attachment #5.
10/10/2024	Health Access California	See Attachment #6.
10/10/2024	Montage Health	See Attachment #7.

September 6, 2024

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

Re: Total Health Care Expenditure Data Submission

Dear Secretary Ghaly and Office of Health Care Affordability (OHCA) Board Members:

Anthem Blue Cross (Anthem) values this dialogue on healthcare spending, as we share your goal of making healthcare more affordable, accessible, and equitable in our state. Anthem has been providing high-quality, affordable health care for Californians for more than 85 years. As one of California's largest health insurers, Anthem provides health care services to more than nine million members in all 58 counties, providing access to more than 500 hospitals, 100,000 doctors, and over 30,000 behavioral health providers.

As OHCA analyzes payers' data leading up to the baseline report, it is critical that this process and engagement be driven by thoughtful discourse, comprehensive analyses, and careful consideration of all the underlying factors that impact healthcare cost. We have highlighted several key factors driving healthcare costs in more detail below and look forward to ongoing discussions with OHCA staff regarding solutions to address these cost drivers.

It is also important to recognize the significant work and innovations being implemented by Anthem and other private payers. To that end, we appreciated the opportunity to present to the OHCA Board last January to share our best practices and cost reduction strategies to improve maternity care quality, equity, and outcomes. While shifting provider reimbursement from volume to value is an essential building block to improve the overall healthcare system and achieve whole health, it is not enough on its own. Our wholistic approach goes further by offering our provider partners the tools and resources necessary to help consumers make the right healthcare decisions at the right time.

We invite you to spend some time reviewing the Elevance Health Advancing Health Together report[1] which dives into significant detail on our delivery system reform approach, which is focused on contracting for outcomes, collaborating for success, and connecting for health. We strongly believe that this partnership with care providers is critical for meaningful progress on healthcare's biggest challenges.

This letter is organized into three sections:

1) We flag several data reporting issues for this year's baseline data submission. We recommend that OHCA work with payers and other stakeholders to revise and refine reporting in these areas for future years to improve the overall quality and integrity of the submitted data.

[1] Anthem Blue Cross is an affiliate Health Plan of Elevance Health, Inc. Through its affiliates, Elevance Health offers a comprehensive suite of commercial, Medicare, and Medicaid plans that focus on whole health and its drivers to help improve outcomes for employers, individuals, families, and communities.

2) We highlight key factors impacting healthcare costs that if not taken into consideration could negatively impact Californians' access to quality healthcare.

3) To support our shared goal in making healthcare more affordable in our state, we urge the Board and OHCA staff to support several legislative policy proposals that will help lower the cost of care. We also urge the Board and OHCA to oppose legislative mandates that impede payers' ability to manage care and ensure that consumers receive the right care, at the right place, and at the right time.

1. *Baseline Data Submission Issues and Considerations to Optimize Future Reporting*

We recognize that this is the first reporting year of the program and that both OHCA and payers have invested a significant amount of time, effort, and resources into standing up the program and implementing the reporting mechanisms. As we move towards future reporting years, Anthem has identified critical issues with the baseline data submission which we believe could serve as opportunities for improvement to help the program better achieve its goals.

- **Resolve timing issues with Medicare shared savings amounts. We would note that Anthem's 2023 non-claims payments (shared savings) show what has actually been paid to providers as of September 2024.** As a result, we are not reporting Medicare shared savings amounts for 2023 because we did not have these numbers to furnish at this time. We currently do not have these numbers because payers are waiting for the final Medicare STARS ratings as well as final Medicare revenue data. These data points are built directly into our shared savings arrangements with providers. We recommend that OHCA either adjust its data submission timeline to a later date or revise its instructions so that payers can estimate these shared savings amounts to the best of their ability for the prior benefit year. If OHCA pushed back the submission date, it would need to be in January two years after the benefit year based on the expected timing for Medicare data from the Centers for Medicare and Medicaid Services (CMS) (e.g., a January 2026 submission date for 2025 benefit year shared savings payments).

- **Ensure that provider entity spending is accurately attributed, reported, and consistently aggregated across payers for the program to be meaningful and effective.** Asking payers to aggregate provider entity medical expenditures by name alone creates significant data integrity and provider attribution issues given that the names in payers' systems can take on a variety of spellings. Without more specificity around defining provider entities, the reporting across payers is subject to individual payers' interpretation.

  As an alternative, we recommend that OHCA look to the Integrated Healthcare Association AMP (Align. Measure. Perform) program. Per the OHCA Attribution Addendum (Addendum)[2], payers would be instructed to map provider entities to the organization code in the Addendum in same manner as they do today for the IHA AMP program. There are significant benefits to this approach, including:
    - Consistency across payers:
    - Consistency with a well-established measurement program already in operation in the state; and

[2] See OHCA Attribution Addendum (June 2024). Available at: https://hcai.ca.gov/wp-content/uploads/2024/07/OHCA-Attribution-Addendum_June-2024-1.pdf.

- Leveraging an existing framework and approach that has familiarity and buy-in from both providers themselves and payers.

Longer term, OHCA, payers, providers, and other stakeholders could explore the feasibility of using the IHA provider directory known as "Symphony."

- **Resolve data discrepancies for partial benefits reporting.** This year's data submission guide instructs payers to estimate the expenses for members whose benefits are carved out (e.g., pharmacy). We warn that this requirement unduly creates an incomplete and potentially inaccurate picture for any given payer's year-over-year medical expenditure trend. It also creates an issue regarding the comparability of medical expenditure trends across payers. Anthem recommends that OHCA revisit this approach for next year through ongoing discussion with stakeholders to develop an improved approach.

- **Prior to any enforcement action with payers or providers, OHCA should develop an appropriate risk adjustment methodology that normalizes for risk.** We do not believe that the age and sex data currently being collected is adequate for this purpose. Without an effective risk adjustment approach, the resulting data will have issues around effectively measuring both payers' and providers' medical expenditure trend performance against the benchmark.

- **Implement a robust data quality and feedback process between OHCA and healthcare entities (payers and providers) before any public reporting or potential enforcement.** This is critical for the overall integrity of the program where we recommend that healthcare entities have the ability to review preliminary results and provide feedback to OHCA.

Lastly, per the OHCA Total Health Care Expenditures Data Submission Guide, Anthem's baseline data submission excludes Medi-Cal Managed Care and Medi-Cal Expenses for Dual Eligibles. This means that Dual Eligible members' expenses covered by Medicare Advantage are reported in this submission, but those same members' Med-Cal related expenses are excluded. OHCA will begin collecting this data for next year's data submission due September 1, 2025.

2. Healthcare Spending Drivers Impacting Cost of Care

Without appropriate consideration of the following factors, the spending benchmark target could lead to healthcare providers having to make the difficult choice of reducing healthcare services to meet the target or face financial penalties. To avoid this, any evaluation of a healthcare entity's performance against the spending target should take the following into consideration:

- **Inflation.** The healthcare delivery system must be able to hire workers, afford medical supplies, and make practical infrastructure updates. This has become increasingly difficult with rising inflation.

- **Labor Costs.** The healthcare sector is labor intensive. While we agree that new technologies can result in productivity improvements, OHCA should also recognize the costs necessary to secure the human capital essential to providing access to quality care.

- **Healthcare Workforce Shortages.** Shortages of providers, including primary care physicians, nurses, behavioral healthcare providers, and specialists increase labor costs.

- **Prescription Drugs and Unregulated Entities.** We expect continued development of new therapies and medications, which will carry substantial costs that are not factored into the proposed spending target. In addition, there is no enforcement mechanism for pharmaceutical manufacturers despite the fact that prescription drugs are the major driver of rising healthcare costs. For example, the median annual price for newly approved drugs increased from $180,000 in 2021 to $222,000 in 2022, signaling double digit annual growth in price for 2024 and beyond.

- **Legislative Mandates that Increase Costs.** Legislative mandates also increase healthcare costs. These include benefit mandates and mandates that impose operational requirements or restrictions on health plans. Each year, legislators introduce dozens of bills that mandate health plans and insurers to cover specific services, as well as bills that eliminate cost sharing and limit utilization management, which increase premiums. The estimated increase in net healthcare expenditures from the select mandate bills that the California Health Benefits Review Program (CHBRP) analyzed for the 2023-24 legislative session totaled more than *$2 billion,* the majority of spending resulting from a pending bill (SB 729) that would mandate coverage of infertility services ($352 million) and a bill (SB 839) that would have mandated coverage of GLP-1 drugs that treat obesity ($1.1 billion).

  In addition, SB 525 (2023) increases the minimum wage for healthcare workers to $25 per hour in the coming years. The UC Berkley Labor Center released a report estimating that total health care expenditures in California would increase by 0.5%, or $2.7 billion, in the first year of the law, due to increased labor costs. The state has recognized the impact that labor costs have on the state budget by delaying the minimum wage for healthcare workers until state revenues have increased substantially.

3. Legislative Policy Changes OHCA Can Support to Contain Costs

Collaboration to address healthcare costs must extend beyond payers and providers to include California policymakers. To help support payers' ability to meet the spending target, we ask that the Board and OHCA support legislative policy changes that would have a meaningful impact on our ability to contain healthcare cost growth and increase affordability, including:

- Prohibiting dishonest billing by off-campus hospital-owned providers;
- Addressing anti-competitive contracting practices by consolidated health systems such as all-or-nothing, anti-tiering, and anti-steering clauses in provider contracts; and,
- Prescription drug reforms, such as:
  - Preventing harmful mark-ups and increased costs for patients by protecting the use of specialty pharmacies to access lower drug costs, and
  - Increasing drug cost transparency by requiring price disclosure from drug manufacturers at time of launch and at time of list price increases and requiring disclosure of patient assistance programs.

Health plans, trusted by employers, individuals, and families to manage care and ensure members receive appropriate and timely medical attention, use several indispensable tools to fulfill this trust. Today, these tools, implemented on behalf of the insurance purchasers, are under significant scrutiny:

- **Utilization Management:** Laws and regulations should not hinder the ability of health plans to carry out reasonable utilization management. Health plans utilize prior authorization in appropriate circumstances to reduce a patient's out-of-pocket expenses, foster patient protection, avert misuse, overuse, and unnecessary or potentially harmful care, and to ensure patient management aligns with evidence-based practices. Absence of these vital tools leaves health plans with limited strategies to guarantee quality and safety, regulate suitable utilization, and control excessive expenditure. This could lead to escalated costs borne by employers and consumers through increased premiums and out-of-pocket expenses. In each legislative session, lawmakers propose bills that seek to limit health plans' ability to use these important utilization management tools. These bills considerably inflate healthcare expenses but fail to be accurately analyzed by the California Health Benefits Review Program (CHBRP). For example, CHRBP has not assessed the premium and cost ramifications of bills that ban utilization management for specific prescription drug categories, or bills that would broadly exempt providers from prior authorization (also referred to as "gold carding").

- **Prescription Drug Coverage Mandates:** It is evident that drug prices continue soaring, representing the second-highest healthcare expenditure, next to hospital costs. Health plans employ several methods to manage drug costs, while simultaneously ensuring affordable access to medications for our members. Methods include step therapy protocols and formularies, which ensure that patients receive safe, effective, lower-cost alternatives to unproven new medications. Limiting health plans' ability to use step therapy can lead to higher premiums, higher out-of-pocket costs for patients, and overall higher healthcare spending.

In summary, we are enthusiastic about furthering OHCA's mission and influencing the direction of California's healthcare market, with a focus on enhancing healthcare accessibility and affordability for all Californians. We believe that achieving this aim necessitates active participation from all healthcare stakeholders, including payers, providers, pharmaceutical manufacturers, and policymakers. These stakeholders play a crucial role in determining the cost and accessibility for the communities we collectively serve.

We hope to have the opportunity to discuss our recommendations and other meaningful policy changes in more detail with Board members and OHCA staff.

Sincerely,

Beth Andersen
President, CA Commercial Business, Anthem Blue Cross

Attachment #2

UNITE HERE HEALTH

September 10, 2024

Mark Ghaly, M.D., Chair Health Care Affordability Board
Kim Johnson, Secretary-Designate California Health and Human Services
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

By email ohca@hcai.ca.gov

Re: Follow up to August 2024 OHCA Board meeting in Monterey County

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

We want to express our gratitude for the Board's recent trip to Monterey County and to ask that the Board impose a 0.1% sector target for the three hospitals, Community Hospital of the Monterey Peninsula (CHOMP), Salinas Valley Health and Natividad, as soon as possible.

First, we know it was a large undertaking to bring the Board meeting to Monterey, especially in light of recent state restrictions on travel. We want to acknowledge the work of the staff in making this happen and the efforts of the Board members and staff to travel to a location far from Sacramento. We were also very impressed by the speakers and the agenda – there can be no doubt now that the excessively high hospital prices in the area are a result of market concentration, and not labor costs or payer mix as the hospitals have argued. Finally, we were heartened to hear the robust discussion from the Board as well as their willingness to listen to hours of testimony, including lengthy public comment. Their commitment to hearing the stories of local people impacted by high hospital prices was apparent to all and greatly appreciated.

We firmly believe that the August meeting presentations, consistent with our own claims experience, suggest that the three Monterey County hospitals merit a 0.1% sector target beginning in 2026. We hope that the additional deep dive into data that was mentioned in the meeting can happen quickly so as not to delay the adoption of a sector target. While we understand that there are considerable complexities in defining sectors and that OHCA would be forging new ground as the first state to do so, we hope that the extreme outlier nature of inpatient and outpatient hospital prices in Monterey County is addressed quickly by OHCA.

The Monterey hospitals are paying attention to the OHCA Board's proceedings. All three issued press releases the day of the August hearing addressing the issue of their high prices, and in the case of CHOMP, a specific commitment to reduce costs and prices (a commitment that is insufficient but is at

least concrete). Continuing to shine a light on the need to do something more about prices in Monterey County will provide even more impetus for the hospitals to commit to real change.

We greatly appreciate the hard work the OHCA Board and its staff are doing to bring some relief to our members.

Sincerely,

Ivana Krajcinovic
Vice President for Healthcare Delivery
UNITE HERE HEALTH

Cc: Members, Health Care Affordability Board
Governor Gavin Newsom
Senate President pro Tempore Toni Atkins
Assembly Speaker Robert Rivas

Attachment #3

American College of Obstetricians and Gynecologists

District IX

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Washington, DC 20024
DIRECT: (202) 863-2564
MAIN: (800) 673-8444
EMAIL: cmccormick@acog.org

September 11, 2024

Secretary Mark Ghaly, M.D.
Chair, Health Care Affordability Board
Department of Health Care Access and Information
202 West El Camino, Suite 800
Sacramento, CA 95833

RE: Definition of Primary Care Provider Proposal: OB/GYN's

Dear Secretary Ghaly:

On behalf of the American College of Obstetricians and Gynecologists (ACOG), District IX, I write to respectfully request that obstetricians and gynecologists (OB-GYNs) be recognized as primary care providers under the Office of Health Care Affordability's primary care spend measurement. OB-GYNs play a critical role in healthcare, not just as specialists but as providers of comprehensive, preventive, and continuous care for women, transgender individuals, and birthing people throughout their lives.

OB-GYNs are often the first and sometimes the only healthcare provider many individuals consult for a wide range of health issues, beyond reproductive care. They manage both acute and chronic medical conditions, offer screenings for conditions such as cardiovascular disease, diabetes, and cancer, and provide counseling on mental health, diet, exercise, and substance use. Excluding OB-GYNs from the definition of primary care providers would ignore the significant preventive care services they provide, which are crucial to the overall health and well-being of women and others under their care.

ACOG's role in national guidance for women's healthcare is well-established. Through the federally funded Women's Preventive Services Initiative (WPSI), ACOG provides comprehensive recommendations for women's preventive health, which are endorsed by the Health Resources and Services Administration (HRSA) and mandated by the Affordable Care Act. These guidelines position OB-GYNs as the primary providers of well-woman visits and key preventive services, including screenings for anxiety, depression, blood pressure, and cholesterol.

The value of OB-GYNs as primary care providers has also been recognized in California state law for decades. Under the Knox-Keene Act (Health and

Safety Code Section 1367.69), OB-GYNs who meet eligibility criteria are classified as primary care physicians, defined as those responsible for providing initial and continuous care, including preventive, acute, chronic, and psychosocial services.[1]

It is crucial that the definition of "primary care provider" reflects the comprehensive and continuous care OB-GYNs provide to women across their lifespan. OB-GYNs offer continuous care from adolescence through menopause, supporting patients during critical life events such as pregnancy, childbirth, and beyond. Excluding OB-GYNs from this definition while allowing other primary care providers to offer OB-GYN services is inappropriate and confusing. This recommendation would uniquely and adversely impact women by limiting funding and support for their primary healthcare.

National data further underscores the role of OB-GYNs in primary care. According to provider data submitted to the Department of Managed Health Care (DMHC), 9% of primary care providers are identified as OB-GYNs, and 72% of OB-GYNs reported by health plans serve as primary care providers. This demonstrates the significant role OB-GYNs already play in offering primary care services, including cancer screenings, vaccinations, and health education.

Given the longstanding legal recognition, national guidelines, and the comprehensive preventive and primary care OB-GYNs provide, we urge the Health Care Affordability Board to reject the recommendation to exclude OB-GYNs from the definition of primary care providers. This exclusion would not only diminish the essential role OB-GYNs play but also risk reducing access to crucial care for women. Therefore, we strongly request that OB-GYNs be included in the definition of primary care providers under the primary care spend measurement.

Please feel free to contact me should you have any questions or need further clarification. We would be happy to provide additional information or engage in further discussions on this important issue.

Sincerely,

Ryan Spencer
Legislative Advocate

[1]**Health and Safety Code Section 1367.69.**
Obstetrician-gynecologists as eligible primary care physicians

(a) On or after January 1, 1995, every health care service plan contract that provides hospital, medical, or surgical coverage, that is issued, amended, delivered, or renewed in this state, shall include obstetrician-gynecologists as eligible primary care physicians, provided they meet the plan's eligibility criteria for all specialists seeking primary care physician status.

(b) For purposes of this section, the term "primary care physician" means a physician, as defined in Section 14254 of the Welfare and Institutions Code, who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, and for initiating referral for specialist care. This means providing care for the majority of health care problems, including, but not limited to, preventive services, acute and chronic conditions, and psychosocial issues.

Cal. Code Regs. tit. 28 § 1300.45.
(m) "Primary care physician'' means a physician who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, or for initiating referral for specialist care. A primary care physician may be either a physician who has limited his practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner.

HEALTH ACCESS CALIFORNIA

September 24, 2024

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

Sandra Hernandez, M.D., Vice Chair
Health Care Affordability Board

Elizabeth Landsberg, Director
Department of Health Care Access and Information

Vishaal Pegany, Deputy Director
Office of Health Care Affordability

2020 W. El Camino
Sacramento, CA 95833

Re: Sector Target of 0.1%: Monterey County Hospitals

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

Health Access California, a statewide health care consumer advocacy coalition committed to quality, affordable health care for all Californians, including those in Monterey, proposes that the three hospitals in Monterey County be treated as a high-cost outlier sector and that these hospitals have a cost growth target of 0.1% for the five years 2026-2030 instead of being allowed to grow at the statewide target of 3% phased-in from 3.5%.

We base this proposal on the research presented at the August 28, 2024, meeting in Seaside, Monterey County, and the testimony offered there by consumers, workers, and key employers, including school districts, as well as the testimony the Board has witnessed over the last fourteen months. The Board also heard from other public purchasers, researchers, and its own staff on a number of data sets and analyses. All the data, research, analysis and public testimony points in the same direction: hospital prices in Monterey are substantially above the statewide average and are driving rate increases for commercial premiums in the region and with probable deleterious effects on statewide premiums as well.

Summary: *Why are Hospital prices in Monterey the Highest in the United States?*

The Board and the public heard:

- It's not the health status of Californians living in Monterey.
- It's not cost shifting because of low Medicare and Medi-Cal reimbursement.
- It's not financial challenges.
- It's not better quality and reduced disparities.
- It's not physician reimbursement.
- It's not wages for nurses and nurse administrators.

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- It is market concentration and market power.

Hospitals in Monterey County have high hospital prices because they can force commercial payers to pay them.

OHCA was created precisely to address such high-cost outliers from market failures. Health Access proposes that these three hospitals be treated as a sector with a cost growth target of 0.1%.

High-Cost Outliers, Evolving Definition of Sectors

The enabling statute requires the Board to establish definitions of sectors no later than October 1, 2027, and to establish sector targets by June 1, 2028[1] but permits the Board to act sooner. While the law suggests some categories to consider as sectors, the law leaves to the Board the definition of sectors.

Importantly, the law allows the Board to evolve the definition of sectors over time. This means that the Board could act soon to define the Monterey County hospital systems as a "high-cost outlier" while continuing to do additional research on other high-cost outlier entities, to define sectors further, and to consider how to further define the threshold for a "high-cost" outlier.

The law on sector targets leads off with a focus on high-cost outliers. The law in the intent section as well as in the legislative debate and the years of discussion leading up to creation of OHCA also included a focus on high-cost outliers. The Sutter anti-trust litigation and the high costs in the regions in which Sutter operates informed the discussion around the creation of OHCA. Based on the evidence to date, by any definition, the hospitals in Monterey County count as "high-cost outliers".

Specifically, the law on sector targets says:

> (e) The methodology for setting a sector target for an individual health care entity shall be developed by taking into account the following:
> (1) Allow for the setting of cost targets based on the entity's status as a high-cost outlier
> (2) Allow for the setting of cost targets that encourage an individual entity to serve health care populations with greater health care risks[2]

There is little or no evidence that the costs for the three Monterey County hospitals are higher because they are serving populations with greater health risks.

Hospital Prices in Monterey County: High-Cost Outliers with Little Justification Aside from Market Power

How High are Hospital Prices in Monterey County?

[1] Health and Safety Code 127502 (l) (2) and also (e) and (j).
[2] Health and Safety Code 127502 (e).

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Hospital prices in Monterey County are among the highest not just in California but in the entire United States. As demonstrated in the August 28, 2024, presentation, by data sets and analyses from CalPERS, Covered California, the RAND hospital price study and OHCA staff, Monterey County inpatient and outpatient hospital prices are more than double the national median—and inpatient prices are almost triple the national median.

The creation of OHCA was driven in part by the recognition that *Bay Area hospital prices* were much, much higher than those in Southern California. That was before we understood how much more expensive Monterey County was than the Bay Area. Bay Area hospitals are at 320% of Medicare while statewide hospitals are at 287% of Medicare. When we began this work, we thought the focus would be on Bay Area hospitals because of the Sutter litigation[3]. But the Monterey County hospitals are more expensive than the average for Bay Area hospitals generally, ranging from 340% of Medicare for Salinas Valley to an astonishing 466% of Medicare for CHOMP[4]. (Note: These data are from prior years: the Board has heard verbal testimony this year that CHOMP is now closer to 560% of Medicare.)

It's NOT the health status of those who live in Monterey

Covered California found that the health status of their enrollees is not worse than those in other regions. Indeed, the health status of Covered California enrollees in Monterey County is somewhat better than those of enrollees in other parts of California.

The OHCA staff can use several sources of data to confirm that this finding applies beyond Covered California enrollees:

- First, HCAI hospital discharge data can be used to develop comparisons of patients adjusted by age, sex and even service utilization.
- Second, health plans contracting in Monterey County may be asked to share data, including prescribing data and other appropriate utilization data, on their enrollees in Monterey County compared to those in other parts of California.[5].

Other methods or data sets to confirm the health status of Monterey County Residents compared to other Californians may exist. We offer these suggestions based on our experience.

It's NOT cost shifting

The data presented to the Board makes clear that higher prices are not correlated with higher Medicare and Medi-Cal utilization: instead, the reverse is true[6]. The more hospitals serve those on Medicare and Medi-Cal, the lower their prices to commercial patients.

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[3] Melnick, Fonkych, 2024, https://jhmhp.amegroups.org/article/view/8976

[4] Whaley et al, slide 116, https://hcai.ca.gov/wp-content/uploads/2024/08/August-2024-Board-Meeting-Presentation-Correct.pdf

[5] We mention prescribing data because it is readily available and because health plans routinely use it for other purposes. Pre-ACA, health plans used prescribing data to deny coverage to those with pre-existing conditions. Post-ACA this is prohibited by both state and federal law.

[6] Slide 125 https://hcai.ca.gov/wp-content/uploads/2024/08/August-2024-Board-Meeting-Presentation-Correct.pdf

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According to the data provided by the staff, and confirmed in other analysis, whether looking at inpatient discharges or all care, including inpatient, outpatient and emergency room use, the proportion of Medicare and Medi-Cal patients at CHOMP is similar to the statewide average, while Natividad and Salinas Valley have somewhat higher Medi-Cal use than the statewide average.

Economist after economist has demonstrated that cost shifting from public programs to private coverage does not occur. One economist, Austin Frakt[7], every few years provides a round-up of articles demonstrating this fact. While the cost-shifting argument has superficial appeal, both the evidence from California as well as a strong and robust literature in health economics demonstrate that it is not true.

It's not financial challenges

Some California hospitals face substantial financial challenges, often made worse by poor management and failure to renegotiate commercial contracts. For example, Madera hospital, which closed eighteen months ago, fell into this category. Other stand-alone hospitals have been found to be sufficiently financially distressed by HCAI to receive state financial assistance in the form of loans. The criteria for the Distressed Hospital Loan Program make clear how close to the edge of closure the distressed hospitals were prior to state action[8].

That's not the Monterey County hospitals. Their operating margins are well above the statewide average. Indeed, CHOMP made $86 million in operating revenue in 2022, over 10% of revenue above expenditures—and that operating revenue of $86 million does not count investment income from the $1 billion in reserves. For a stand-alone hospital to have $1 billion in reserves is extraordinary. Doing this while charging the highest commercial prices not just in California but in the nation makes plain that the driver is market power, not financial distress. In 2021, CHOMP had an operating margin over 14%, far above most California hospitals. Even during the worst of the pandemic, the operating margin for CHOMP was over 10%.

It's NOT better quality and greater health equity

As the analysis provided to the Board demonstrates, these three hospitals have no higher quality: the Medicare star ratings for two of the three are a 3-star rating, the middle of the pack, and the other hospital rates 4-stars while the statewide average is 3.5 on a 5-point scale.

The OHCA staff may wish to look at several other sources of data on hospital quality to confirm the Medicare ratings.

It's not physician reimbursement

The same sets of data used to look at hospital prices make clear that physician reimbursement and prices in Monterey County are somewhat below average by some measures.

It's not wages of nurses or nursing administrators

[7] Austin Frakt, the Incidental Economist:
[8] https://hcai.ca.gov/wp-content/uploads/2023/05/DHLP-Powerpoint-Draft-Evaluation-Methodology-Webinar.pdf and https://hcai.ca.gov/wp-content/uploads/2023/08/DHLP-Loan-Award-Press-Release.pdf

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The data presented by OHCA staff shows that wages for hospital nurses and nursing administrators at the three Monterey County hospitals fall between the statewide average and the higher Bay Area average. In contrast, hospital administrator wages are significantly higher than the statewide average, almost double in some years, at least at Salinas Valley and CHOMP.

Health care consolidation and hospital market power account for higher prices

Market power and market consolidation account for a substantial share of the difference in prices received by Monterey hospitals compared to California hospitals or even Bay Area hospitals. This is based on the available research whether it's the five rounds of the RAND hospital price studies, the analysis by the Office, the letter from the Berkeley Labor Center, or the verbal testimony of Christopher Whaley, one of the co-authors of the five rounds of the RAND hospital price studies[9]. The time and distance standards established in 1975 for the DMHC coverage requiring that a consumer be within 15 miles or 30 minutes for hospital care provide a convenient metric that substantiates that CHOMP is a monopoly while Natividad and Salinas Valley constitute a duopoly for hospital care.

The Berkeley Labor Center letter cites one study that indicates that monopoly hospital prices can be expected to be 12.5% higher while duopoly hospital prices are 7.6% higher. But this is only about half the price differential for these hospitals compared to those in the Bay Area.

This raises for us the question of what else accounts for the difference in Monterey hospital prices? Is it an abuse of market power to accumulate revenue? It appears to be the exercise of market power to extract rents, in the language of economists, at considerable pain to consumers and purchasers.

Even if the Monterey County hospitals re-benched commercial prices to the same percentage of Medicare as for the average of Bay Area hospitals, it would be a substantial savings, particularly for those consumers and commercial payers using CHOMP or Natividad. The Board should also consider whether the Monterey hospitals should eventually be re-benchmarked closer to the statewide average.

Correlation of Revenues and Spending

The Board heard a discussion from Chris Whaley, a health economist nationally known for his study of hospital prices, about endogenous and exogenous variables driving hospital spending.[10] We also point to Gerard Anderson, who decades ago co-authored with Uwe Reinhardt, the famous article titled "It's the Prices, Stupid" as well as co-authoring a more recent article titled "It's Still the Prices, Stupid: Why the United States Spends So Much on Health Care, and a Tribute to Uwe Reinhardt" [11]. We also recall Roemer's law[12], developed in 1959 and validated after the implementation of

[9] https://www.rand.org/health-care/projects/hospital-pricing.html
[10] https://www.rand.org/health-care/projects/hospital-pricing.html
[11] https://www.healthaffairs.org/doi/10.1377/hlthaff.22.3.89 and https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05144
[12] Do More Hospital Beds Lead to Higher Hospitalization Rates? A Spatial Examination of Roemer's Law

Medicare and Medicaid by Milt Roemer, then of UCLA[13], which stated in short that a built hospital bed is a filled hospital bed. A recent study confirms this and adds lack of equity as a factor: Black women are more likely to have Cesarean sections when operating rooms are empty, just as MRIs and CT scans are more likely when the equipment is not being used[14].

Capacity and spending go hand in hand. More revenue equals more spending, whether warranted or not. Less revenue can lead to greater efficiency if done well.

System or Larger "Family" of Entities, Not Individual Facilities

Most state analyses of hospital revenues and spending looks at individual facilities, often using the data HCAI has been collecting since the early 1980s. For example, a recent analysis by Glenn Melnick, USC, found that California hospitals had revenues in excess of expenditures or profits of $9 billion[15] but again this looked largely at individual facilities rather than health systems. The focus on individual facilities rather than systems or groups of entities underestimates how much revenue is extracted from payers.

Hospitals with excess revenues often pull those revenues out of the individual facility or facilities into the health system or related group of entities. In the health system, stored-up reserves can be used to finance further consolidation and to earn investment revenue, which in some cases can be very substantial. When hospitals complain about insufficient revenue, they almost always point to net operating revenue at the facility level, ignoring their system level finances.

The three hospitals in Monterey are stand-alone hospitals that are not upstreaming money to multi-state systems.[16] But even these stand-alone hospitals may well be parking money in their hospital systems or group of entities rather than at the hospital level. For example, CHOMP told local media that it has a reserve of $1 billion, an astonishing amount for a single 286-bed hospital. "Family" or group of entities refers to the reality that hospital systems also include outpatient care, medical groups, imaging, labs and more that are not the licensed general acute care hospital, licensed under Health and Safety Code 1250.[17]

Health Access proposes that in order to conduct a meaningful Market Impact Analysis, HCAI rely not only on existing data reporting to HCAI but that it also requests full audited financial statements, including statements of financial position that will provide information on the reserves at the system-level as well as at the facility level. Having audited financial statements and statements of financial position will better allow OHCA to judge the possible impact of a significantly lower target

[13] Milt Roemer who was said to have helped President Truman develop his health care proposal as well as the World Health Organization and the Saskatchewan single payer system was helpful to Health Access in years gone by but is, of course, no longer with us. Dr. Milton Roemer; Expert on Public Health Taught at UCLA - Los Angeles Times (latimes.com)
[14] Drivers of Racial Differences in C-Sections | NBER and Doctors Give Black Women Unneeded C-Sections to Fill Operating Rooms, Study Suggests - The New York Times (nytimes.com)
[15] Melnick, August 2024, https://www.chcf.org/publication/tracking-financial-health-ca-hospitals/
[16] The point about systems rather than individual facilities will be even more relevant when the analysis turns to systems such as Sutter and (what was the system that failed to invest in Madera?).
[17] The general acute care hospital is required to meet both seismic requirements and nurse ratios. The other entities, including outpatient settings on the hospital campus such as medical office buildings are not required to meet these safety standards.

for these hospitals. We also continue to point to the need to collect data at the system or group level rather than the individual facility level.

Cost Growth Target, Not Rate Regulation, Not Price Setting

The cost growth targets set by the Board with the input of the Advisory Committee and staff are based on the premise that if given a growth target, an entity will manage its budget and resources to hit that target. This is a different policy premise than rate regulation which regulates the prices of specific services. It is also a different policy premise than reference pricing or other price caps, such the Oregon state employee health plan capping hospital services at 200% of Medicare or the Montana state employee health establishing payment rates as a multiple of Medicare, from 220 % to 250% depending on the service[18]. Health Access supports all of these approaches to cost containment. We also supported the proposal in AB 3087 (Kalra) of 2018 that would have capped spending by each health care entity at a percentage of Medicare.[19]

The policy premise behind the Office is that given a cost growth target, along with an emphasis on equity and quality, individual health care entities can manage their budget to hit the targets, lowering costs while improving outcomes and equity without destabilizing their workforce in the pursuit of profits. The three hospitals in Monterey with their high hospital costs create an opportunity to test that case where the consumer pain is the worst.

Hospitals Can Control Costs while Improving Outcomes and Reducing Disparities: A Partial List

Some health systems have focused on controlling costs while improving care. Others protest too much about their inability to control costs, often pointing to costs that are in fact revenue generators such as drugs administered in a hospital, technology or hospital capacity itself. What follows is a brief and very partial list of ways that hospitals can control costs while improving care.

Billing and Contracting Practices

Monterey County hospitals continue to use billed charges as the basis for contracting, even though billed charges or sticker price are fully within the control of the hospital. Most California hospitals have long since moved to negotiated rates. We have proposed that the Monterey County hospitals should benchmark to the prices of other Bay Area hospitals, at a minimum, and preferably to the statewide average, expressed as a percentage of Medicare. These moves alone would lower costs.

According to Dr. Angela Riley, medical director, UNITE HERE HEALTH, the national trust fund for hospitality workers, CHOMP charges 800% of what Medicare pays for some drugs administered in the hospital setting. This is outrageous. Lowering this markup to 200% or 300% of Medicare would again lower costs and immediately save consumers and other purchasers money. Again, benchmarking hospital prices to Medicare prices is a good first step.

[18] https://nashp.org/independent-analysis-finds-montana-has-saved-millions-by-moving-hospital-rate-negotiations-to-reference-based-pricing/

[19] The bill did not specify the percentage of Medicare before the measure failed to proceed after passing its first committee vote.

Improved Care

Other steps would improve care and reduce disparities. Since the enactment of the ACA, hospitals have reduced readmissions significantly. Similarly, most California hospitals have reduced hospital-acquired infections, thus saving money and improving outcomes. More challenging to accomplish, but no less important, is reducing hospital use for ambulatory sensitive conditions such as the major chronic conditions. Use of the emergency room to treat an ambulatory sensitive condition should be seen as a system failure, not a revenue generator.

Kaiser Permanente was able to dramatically reduce use of emergency room care for asthma by more effective management of this condition. Clinics serving uninsured children had similar success. The goal is not longer stays or more frequent ER visits but keeping people healthy.

Prevention: Vaccinations

Simple, low-cost interventions to reduce hospitalization also include vaccination campaigns, from flu shots and Covid vaccines to childhood immunizations. Reducing hospital use for these diseases is not a mystery or a high-cost effort: vaccines work, so do vaccination campaigns.

Drugs and Technology: Revenue Generators

While hospitals point to the costs of drugs and technology as cost centers, in truth, both are revenue generators for hospitals which routinely charge purchasers more than the drugs or technology cost the hospital to purchase—and use both to drive consumption in order to generate more revenue for the hospital. Improvements in care are valuable but only if they improve outcomes.

Capital Expenditures

One of the most vivid consumer stories we heard in Monterey was a consumer who described her experience of walking through empty buildings on the hospital grounds, including a basketball court. Contrast this with the stories of MLK hospital in South Central Los Angeles where patients routinely spill out of the buildings and into hallways, even when not at the height of a global pandemic.

While we are not suggesting a return to the Certificate of Need (CON) program that precipitated the creation of the Office of Statewide Health Planning and Development, we do suggest that excessive capital expenditures are one indicators of excessively high hospital costs which are in excess of what is needed to provide care to that community.

Again, this is a partial list of things hospitals can do to control hospital costs while improving quality and equity and maintaining access. A hospital system committed to the triple aim of lower costs, improved outcomes and greater equity could find many more steps to take.

The Larger Context of Health Care Costs and Consumer Affordability

We appreciate the effort of staff to place the experience of consumers in Monterey County in a larger context of lack of affordability of health care and coverage. A few points to add:

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- Deductibles: the staff rightly highlighted that the average deductible amount has risen but equally importantly, deductibles are far more prevalent for California working families. Twenty years ago, deductibles were relatively rare for employer coverage in the private sector in California, affecting 1 out of 3 workers: today almost 8 out 10 workers with job-based coverage in California have a deductible and the median deductible for family coverage was nearly $4,000 in 2022[20].
- Coinsurance vs. Copays: Another sign of the stress on affordability is the increasing prevalence of coinsurance, a percentage of the underlying cost, rather than fixed amount copays. By reports from individual consumers, almost all coverage in Monterey County relies on coinsurance, which exposes consumers to cost-sharing that is literally unknowable in advance.
- Share of Premium: Just as deductibles have risen faster than wages, so has the share of premium paid by workers, particularly for family coverage.

We add these examples of problems with consumer affordability to the overview provided by staff because in our view, understanding consumer pain will require multiple measures. Focusing on a few measures will allow costs to be shifted in other ways that cause consumer pain.

The need to monitor multiple measures of consumer affordability to reduce the likelihood that costs are merely shifted from premiums to out of pocket costs or from deductibles to share of premiums applies to OHCA's monitoring of consumer affordability as well as to the rate review processes conducted by the Department of Managed Health Care and the Department of Insurance. Rate review is the opportunity for the work of OHCA to be felt by consumers and other purchasers. Until these agency activities are effectively connected, consumers will not benefit from the work of OHCA as much as intended by the law.

Market Analysis Appropriate but Not Sufficient

Health Access appreciates the suggestion of Secretary Ghaly that the staff conduct a a market analysis focused specifically on the Monterey County hospitals under the same authority granted to do merger reviews. The law deliberately gave the Office the authority to do such market conduct studies to delve deeper into specific topics. The outcry around the lack of affordability health care in Monterey County makes this an appropriate first topic for such an effort. The staff has already done a significant amount of research, as have other public purchasers, the RAND hospital price studies, and others.

A market analysis is a good first step. The Board has the authority to do more, and it should.

Lower Cost Growth Target

The Office of Health Care Affordability was created because market failures in health care allow high prices for health care costs for commercial coverage broadly. Throughout the legislative discussion, there was also a focus on high-cost outliers, specific entities or regions or "sectors" that have high prices, whether it is anesthesiologists charging 900% of Medicare or outlier hospital systems.

[20] https://laborcenter.berkeley.edu/measuring-consumer-affordability/

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The Office was given authority to set lower cost growth targets, but not negative targets, precisely to address both the broad need to slow health care spending, especially for commercial coverage, and the more focused problems caused by high-cost outliers. Whether it is CalPERS, Covered California, school districts, the union trust funds covering specific groups of workers, or the other consumers who spoke up at the Monterey hearing, the Board heard loud and clear about the problems with hospital costs in Monterey County. The Board can act to set a specific, lower cost growth target for the Monterey County hospitals.

We have suggested additional research that can support this proposal. The Board and the Office may wish to consider this further research before acting. As with other targets, we propose a five-year target to allow the entities time to take action to manage their budgets consistent with the cost target.[21]

Health Access proposes a cost growth target of 0.1% for the years 2026-2030 for the Monterey County hospitals. Our reading of the law is that the Board could act prior to June 1, 2025, to set a target for 2026 and beyond[22].

Sincerely,

Beth Capell, Ph.D.
Policy Consultant

Amanda McAllister-Wallner
Interim Executive Director

CC: Members of the Health Care Affordability Board
Incoming California Health and Human Services Secretary Kim Johnson
Kimberly Chen, Deputy Secretary, California Health and Human Services Agency
Senator Mike McGuire, President Pro Tempore
Assemblymember Robert Rivas, Speaker of the Assembly
Senator Richard Roth, Chair, Senate Health Committee
Assemblymember Mia Bonta, Chair, Assembly Health Committee
Mary Watanabe, Director, Department of Managed Health Care
Michelle Baas, Director, Department of Health Care Services

Monterey Legislative Delegation:
Assemblymember Robert Rivas, Speaker of the Assembly
Senator Anna Caballero, Chair, Senate Appropriations Committee
Senator John Laird
Assemblymember Dawn Addis

[21] We recognize that the period of 2026-2030 extends beyond the 2025-2029 period for statewide targets. We propose 2026-2030 for the Monterey hospitals for several reasons: 1) Five years allows these hospitals time to come into compliance. 2) This target is unlikely to be set before 2025 and the law, rightly, requires notice of a target. 3) The proposed target for the Monterey hospitals is not linked to the statewide target. 4) Finally, as important as these hospitals are in Monterey County, unlike some other systems, these hospitals do not move markets across a number of geographic regions.

[22] If the law permitted a negative target, we would propose that. To our regret, the law states "the definition of "Health care cost target" means the target percentage for the maximum annual *increase* in per capita total health care expenditures." (Emphasis added.) Health and Safety Code section 127500.2 (j).

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Attachment #5

California Hospital Association

October 9, 2024

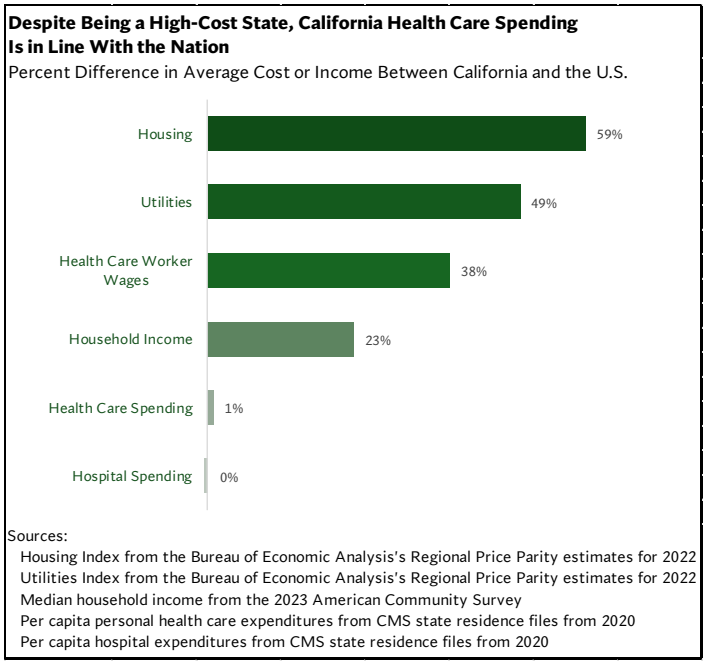
Health Care Affordability Board
2020 W El Camino Ave.
Sacramento, CA 95833

Subject: **CHA Comments on the August 2024 Health Care Affordability Board Meeting**
(Submitted via Email to Megan Brubaker)

The California Hospital Association (CHA), on behalf of its more than 400 hospital and health system members, appreciates the opportunity to comment on the August 2024 Health Care Affordability Board meeting. The Office of Health Care Affordability (OHCA) has an historic opportunity to transform health care delivery in California, but it cannot achieve its goals of affordable, high-quality, equitable care delivery without a thorough understanding of the health care landscape. The August meeting focused on regional variation in health care spending throughout California and the United States, with a focus on hospital spending. The information presented showcased stark regional differences in health care spending throughout the state and assessments of their causes and consequences. However, certain perspectives, context, and analysis were missing. This letter aims to fill those gaps and offer alternative views on the matters under consideration. Moving forward, the office must ensure that the perspectives and information presented offer a complete and accurate picture.

Regional Comparisons of Hospital Reimbursement Lack Critical Context

The August board meeting included several presentations showing that California has higher health care costs than other states, and that certain regions like the Bay Area and regions to its south along the coast have especially higher costs. While most of this information was well grounded, it lacked critical context. Namely, that **almost everything is more expensive in California**, especially in certain regions. The question worth asking is whether health care is more expensive than would be expected given the state's and certain regions' extraordinarily high cost of living. The answer is no.



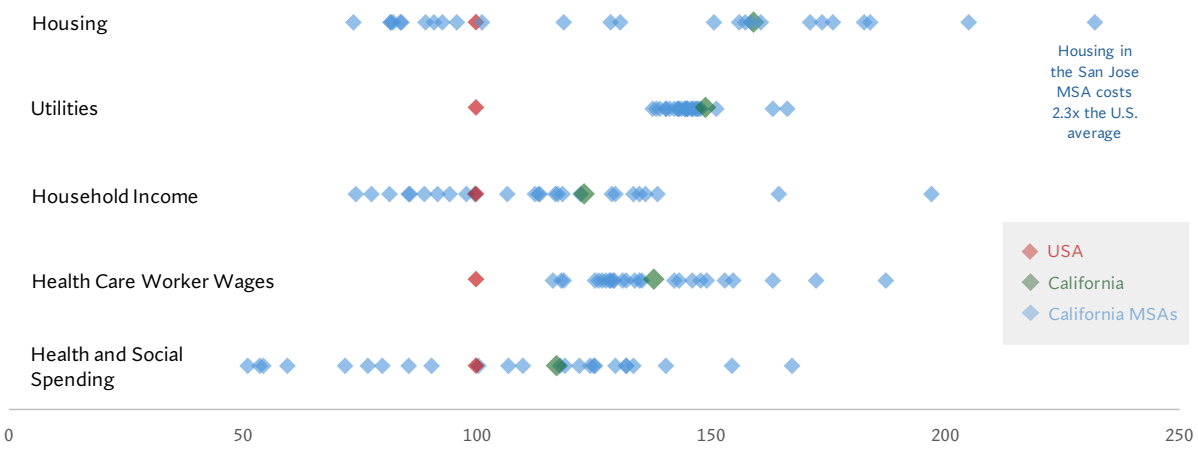
Costs Are High in California. Per capita spending on health care and hospital care in

California is in line with the national average, despite everything else being far more expensive here. Many reasons underlay this surprising fact. Californians are relatively young, correspondingly healthier, and have enjoyed a long history of widely available, clinically integrated care. On the other hand, California health care providers face extraordinary cost pressures such as astronomical real estate costs, outsized energy bills, and an imperative to pay their workers high wages to match California's high cost of living, as shown in the figure on page 1.

Californians in Some Areas Face Astoundingly High Costs of Living. Californians' costs for housing and other necessities vary widely throughout the state. The figure below provides a snapshot of the incredible variation throughout the state in spending on housing and utilities, as well as household incomes, health care worker wages, and overall health and social spending. It shows extraordinarily high costs of living in Northern California areas like the Bay Area and regions to its south along the coast. These high regional costs of living are passed through to local hospitals, particularly through high labor costs.

Differences in Cost of Living Must Be Considered When Evaluating Regional Differences in Health Spending

Comparison of Spending Indices: U.S., California, and California Metropolitan Statistical Areas (MSA)



Sources: CHA analysis of data from the Bureau of Economic Analysis and American Community Survey

It Is Essential to Control for Regional Cost Differences When Evaluating Hospital Spending. Two comparisons between California hospital prices and national prices were presented at the August board meeting, both showing that hospital care is more expensive here than elsewhere. The first simply showed that California health care costs are higher, but included no adjustments to control for California's overall higher cost of living, creating a misleading impression that health care is uniquely expensive here.

The second compared hospital prices to what Medicare would have paid. Here, things become more complicated as this approach partially — **but ultimately inadequately** — controls for regional variation in underlying costs. Medicare rates vary geographically based on differences in the hospital labor costs, as determined by the area wage index. However, according to research out of Stanford and the University of Southern California, deficiencies in the area wage index result in significant and growing underpayment

from Medicare for California hospitals located in high-cost regions.[1] For example, while fee-for-service Medicare paid California hospitals in regions with low area wage index scores fairly close to at cost as of 2019, it underpaid hospitals with high area wage index scores by upwards of 50% or even 75%. This deficiency in Medicare payment policy inevitably makes hospitals in areas that are disproportionately undercompensated by Medicare appear more expensive, despite their higher commercial rates being necessary to sustain their operations. Accordingly, even using relative payment benchmarks, like comparing commercial payments to Medicare benchmark rates, can mislead due to deficiencies in how the underlying benchmark rates are determined.

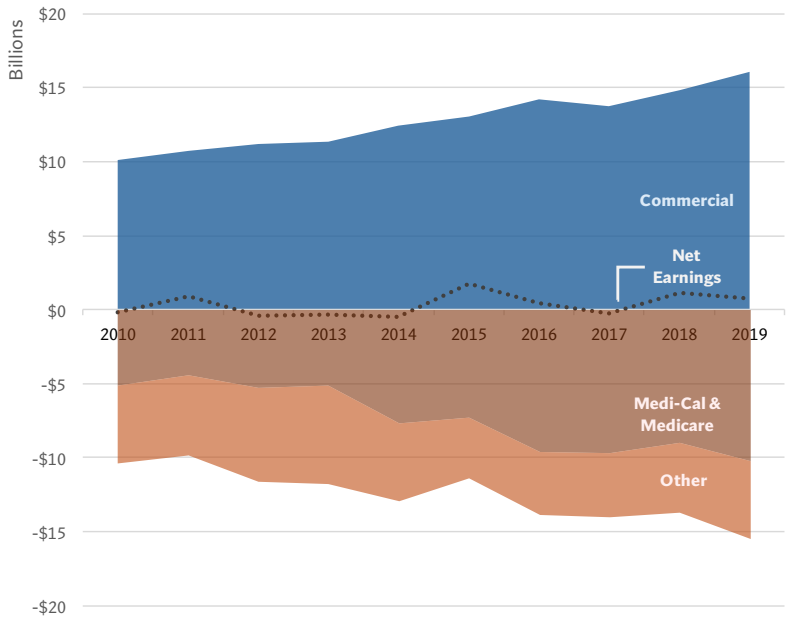
The Cost Shift Is Real, and Getting Worse

Cost shifting occurs when one entity underpays for a good or service, resulting in another entity overpaying for the good or service to ensure the producer's costs are covered. The phenomenon is commonplace in health care finance, where reimbursement shortfalls from government payers — namely Medicare and Medicaid — are cross subsidized by relatively higher payments from commercial insurers. Nevertheless, the concept is debated, with some (including one witness at the August board meeting) challenging whether cost shifting plays any role in hospital finance. However, it is difficult to see how this view squares with the data and overall landscape of the hospital field.

Medicare Pays 75 Cents on the Dollar for Hospital Care. In 2019, hospitals provided more care to Medicare patients than Californians with any other type of health care coverage. That year, California's hospitals provided about $40 billion in care to Medicare patients. However, due to the growing inadequacy of Medicare reimbursement, California's hospitals were paid just $30 billion for this care, creating $10 billion in losses that hospitals were forced to make up elsewhere. This enormous shortfall, representing nearly 10% of statewide hospital expenses, grew significantly over the preceding decade because Medicare payment growth failed to keep up with the cost of providing hospital care. (Medi-Cal payments similarly fall short; in fact, Medi-Cal reimbursement is closer to the actual cost of care only because hospitals put up their own funding to draw down federal Medicaid dollars and thereby increase their net reimbursement.)

Hospitals' Commercial Earnings Have Risen to Offset Losses From Other Payers

Annual Earnings (Losses) by Payer Type



Source: Annual Financial Disclosure Reports: 2010-2019

Hospitals Turn to Commercial Payers to Keep Their Doors Open. As hospitals fight to keep providing patient care in the face of these massive losses from government payers, they have few good options

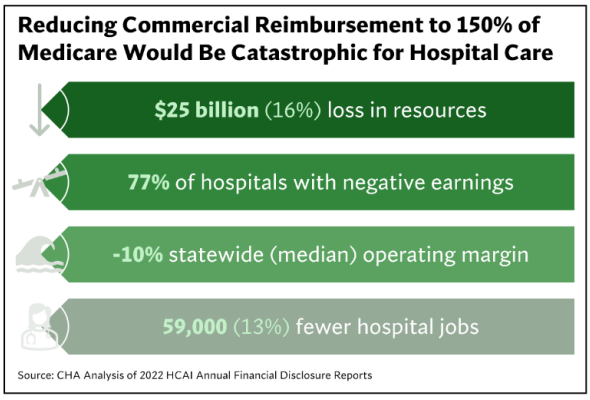
[1] Gaudette É, Bhattacharya J. California Hospitals' Rapidly Declining Traditional Medicare Operating Margins. Forum Health Econ Policy. 2023 Mar 7;26(1):1-12. doi: 10.1515/fhep-2022-0038. PMID: 36880485.

to ensure their costs are covered. Historically, the best approach to ensure hospitals can stay open has been to rely on commercial payers to make up for the losses from government payers. As the figure on the prior page shows, hospitals' commercial earnings are almost perfectly offset by losses from Medicare, Medicaid, and other payers. Moreover, this tight relationship holds throughout the nearly decade-long period, with every increase in commercial reimbursement offset by growing losses elsewhere, keeping earnings near zero. These results are corroborated by recent research on California's hospitals that show growing losses on Medicare fee for service since 2005, earnings growth for the commercially insured, and operating margins close to zero. Cost shifting predicts the consistency between these trends. A pure market power theory, by contrast, would allow higher commercial earnings to be retained as higher overall earnings.

Hospitals That Cannot Cost Shift Close or Merge. Hospitals do not unilaterally set their commercial prices. Rather, they do so through negotiation with their health plan partners. In many cases, one or two health plans may dominate a given area or market — and use their market power to restrain hospital payments, even in circumstances where higher payments are needed to offset declining government reimbursement. A 2021 study in *Health Affairs* showed what can happen when hospitals cannot recoup their losses through improved commercial payments: they close, or they merge with another hospital.[2] While mergers sustain access to care and jobs, closures sacrifice both, endangering the communities that rely on their local hospitals for their lives and livelihoods.

Losses from Government Payers Likely to Increase through the End of the Decade. Almost 300 elderly Californians are added to the Medicare rolls every day, a trend likely to continue for the foreseeable future. Most are retirees, meaning they are exchanging their commercial job-based coverage for Medicare the day they turn 65. This shift toward Medicare coverage will severely test hospital finances. The reason: the job-based commercial coverage for the 64-year-old hospital patient covers their cost of care, and more. By contrast, the 65-year-old patient's Medicare coverage pays 75% of the cost of care. Consequently, a one-day change in a patient's age, and therefore their type of coverage, lowers reimbursement for their hospital visit by half. As the relative share of Medicare-to-commercially-insured patients inexorably grows over the next decade, accompanied by further deterioration in the adequacy of Medicare payments, hospitals will have to balance growing financial losses through higher reimbursement from other payers, service reductions, closures, and other measures.

Reducing Commercial Reimbursement to 150% of Medicare Would Be Catastrophic. At the August board meeting, it was suggested that hospitals should be able to make do with commercial reimbursement no higher than 150% of what Medicare pays. The figure on the right shows what such a drop would do to hospital care in California. Resources for patient care would drop by tens of billions of dollars, nearly four in five hospitals would operate in the red, and hospitals would be forced to reduce their workforces by as many as 59,000 jobs. The impact on patients would be devastating, and would violate OHCA's charge to make care affordable while preserving access, equity, and quality.



[2] Chernew, Michael E., et al. "Public Payment Rates for Hospitals and the Potential for Consolidation-Induced Cost Shifting." *Health Affairs*, vol. 40, no. 8, 1 Aug. 2021, pp. 1277–1285, https://doi.org/10.1377/hlthaff.2021.00201.

Hospital Revenues Support Patient Care

CHA's August 2024 letter to the OHCA board showed that hospital revenues line up almost perfectly with the cost of providing care. However, certain information presented at the August board meeting left a mistaken impression that California hospitals' revenues often support other purposes. This is far from the truth.

Data Presented to OHCA Misrepresented Hospitals' Current Financial State. At the August board meeting, a witness presented data showing that California's hospitals, taken together, enjoyed a healthy operating margin of 11.1% in 2022 (with the national figure being even higher at 13%). Both state and federal data show that excess returns are not, however, a driver of hospital costs. Rather, these data reveal that the data presented at the August board meeting are highly suspect and out of line with other analyses of the same and similar data. The Medicare Payment Advisory Commission (MedPAC) recently analyzed the same data presented at the board meeting for hospitals nationally, finding that their all-payer operating margin averaged 2.7% in 2022, one-fifth of the 13% figure shared at the board meeting. A Milliman analysis corroborated the MedPAC estimate. Meanwhile, state data also contradict the data presented at the board meeting. For 2022, California hospitals reported an operating margin of just 1.04% to the Department of Health Care Access and Information, far below the 3% level that credit agencies deem necessary for hospitals to meet their financial obligations. Contrary to the story conveyed at the board meeting, California's hospitals continue to struggle to financially recover from the COVID-19 pandemic, seeking partnerships and state loans to obtain basic operating capital, eliminating unsustainable service lines, and taking various other actions just to keep their doors open.

Eliminating Hospital Earnings Would Imperceptibly Change Health Care Costs, While Jeopardizing Patient Care. For the entire period from 2010 to 2019, California's hospitals barely broke even. Collectively, their margins when comparing their direct (net) patient revenues to their expenses were just 0.41%, a wholly unsustainable margin were it not for other sources of revenue keeping hospitals afloat. Total margins, including all sources of revenue, tell a largely similar story. Most recently in 2022, hospitals' total margins, including all sources of income, were just 1.3% percent on a statewide basis; again, far below what credit ratings agencies understand is necessary to sustain services.

These margins translate into $1.7 billion in earnings on roughly $130 billion of expenses. The earnings reflect roughly 0.4% of total health care spending in California. Accordingly, OHCA could eliminate all hospital margins and total health care spending would go down by roughly $4 per person per month — a virtually imperceptible difference. Meanwhile, hospital care would crumble from a lack of resources to maintain physical infrastructures, invest in new technologies and treatments, recruit and retain their workforce, and expand capacity to meet the growing needs of California's aging population.

Nonsupervisory Labor Costs Are Hospitals' Largest Expense. Roughly half of California hospitals' expenses go toward labor. If physician payments and salaries are included, the share increases to almost 60%. What's more, this spending overwhelmingly is for direct patient care and support, with 85% of total labor expenses going to nonsupervisory workers in the form of wages and benefits. Most of the remainder goes to direct staff supervisors, such as nursing supervisors. Of all hospital spending on worker wages and salaries, just 1.7% went to high-level hospital administrators in 2021. Removing all these expenses on high-level hospital administrators would reduce statewide health care spending by roughly two-tenths of 1%, saving Californians less than $2 per person per month.

There Are Many Drivers of Hospital Spending, Not Simply Market Concentration

Hospital spending is driven by a variety of factors, including:

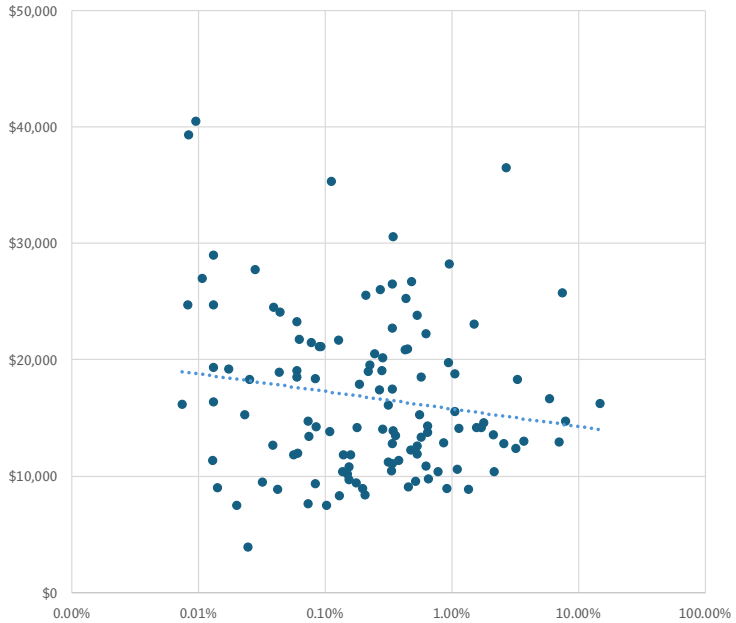
- Regional differences in the cost of living and their effect on labor costs (hospitals' highest category of expense)
- Differences in population health needs, such as the age of a hospital's surrounding population
- Differences in utilization levels that spread the fixed costs of running a hospital across higher or lower numbers of patients
- Idiosyncratic patterns of profitable service and payer lines cross-subsidizing losses elsewhere
- The provision of highly specialized care for patients with the most complex, severe conditions
- Differing levels of investment in clinical training

Rather than confronting such complexities head on, one factor was singled out at the August board meeting as driving variation in health care spending: market concentration. The analysis below shows that market concentration is not major driver of differences in hospital spending.

Statewide Market Share Is Not Linked to Higher Reimbursement. If market concentration is a primary driver of differences in reimbursement levels, hospitals and systems with greater market shares should translate their dominant market position into higher reimbursement. However, the figure to the left shows this is not the case — hospitals with greater statewide market shares have, on average, lower reimbursement than other hospitals. (Hospitals that are part of a system are treated as a single entity.) Clearly, other factors are driving these differences in hospital reimbursement.

Regional Market Share Is Not Associated with Higher Reimbursement. Statewide market share may represent the wrong measure of concentration since most hospital care is delivered to local residents. Instead, the question should be looked at regionally. The figure on the next page shows the relationships between hospitals and hospital systems' regional market shares and their reimbursement levels. In 13 of the 18 regions, hospital reimbursement trends downward as their regional market share increases, indicating that market power is not a primary determinant of local differences in hospital reimbursement. To the contrary, this and the statewide result indicates that other factors — such as greater efficiency through economies of scale — may be influential drivers.

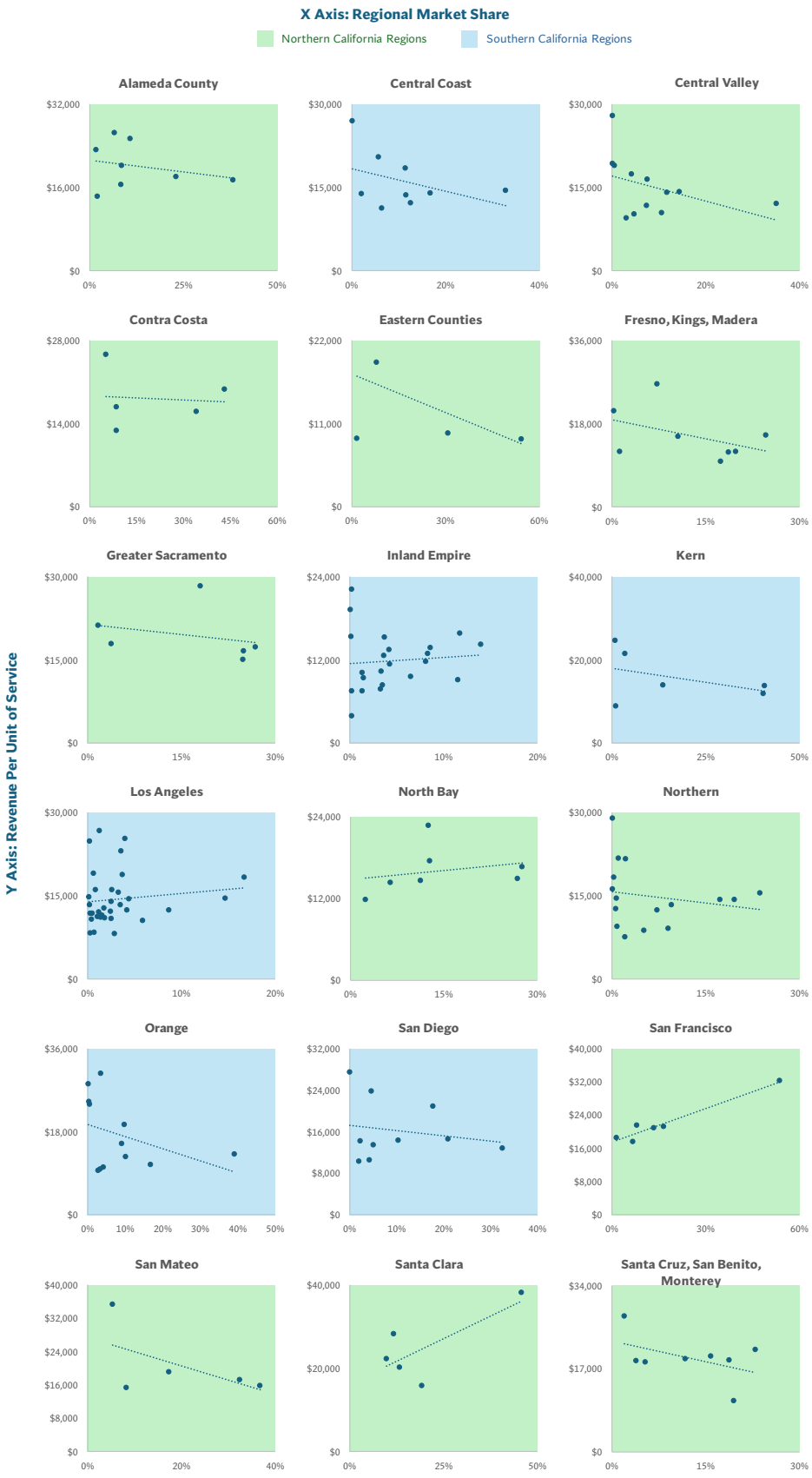
Statewide Market Share and Reimbursement Levels Are Negatively Correlated



Markers display all-payer average revenue per case mix-adjusted unit of service for each hospital or hospital system. For hospital systems, their aggregate market share is captured across their hospitals.

Data is from HCAI Annual Financial Disclosure Files for the years 2021 through 2023.

Regional Market Share Not Generally Associated With Higher Hospital Reimbursement

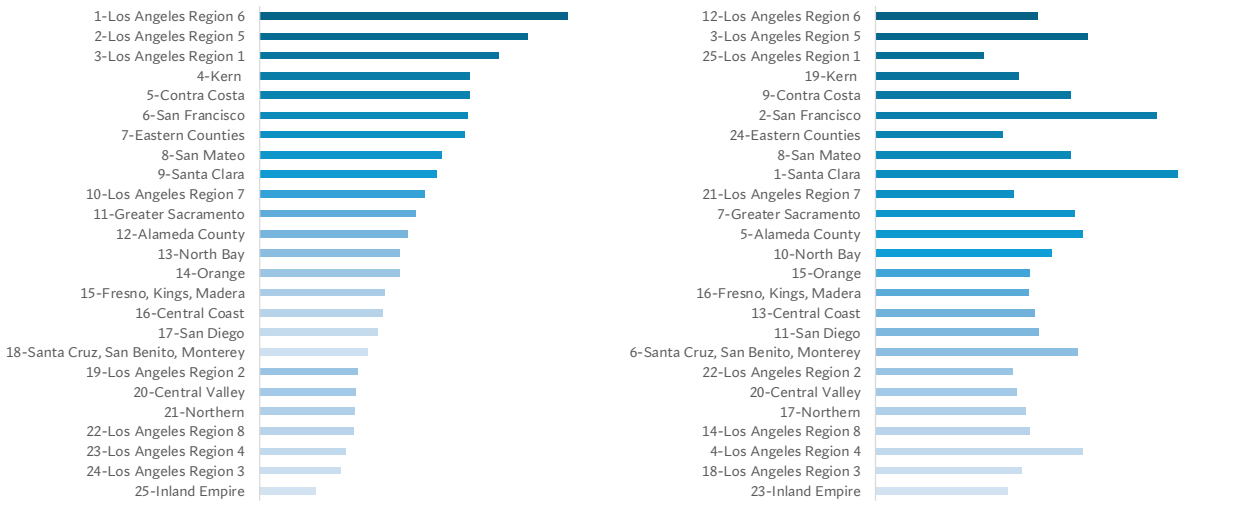


Markers display all-payer average revenue per case mix-adjusted unit of service for each hospital or hospital system. For hospital systems, their aggregate regional market share is captured across their hospitals.

Data is from HCAI Annual Financial Disclosure Files for the years 2021 - 2023.

Regional Variation in Hospital Market Concentration Does Not Clearly Tie to Higher Reimbursement. Instead of an individual hospital or system's market share being the determining factor, hospital pricing could depend on overall regional market dynamics. Here, under the market concentration theory, hospital reimbursement levels should vary according to how concentrated a region's hospital market is. However, the data once again do not clearly bear this out. The figure below shows no clear relationship between hospital reimbursement levels and the degree to which an OHCA region has a concentrated hospital market, as measured by each region's Herfindahl-Hirschman Index (HHI) score (HHI is a widely accepted measure of market concentration).

Hospital Reimbursement Does Not Clearly Track Regional Differences in Market Concentration



Left panel shows each region's relative Herfindahl-Hirschman Index (HHI) score based on each hospital or hospital system's share of inpatient and outpatient services provided in a region. Right panel shows average reimbursement level for hospitals in a region, determined based on net patient revenue per unit of service. The numbers before their names both reflect their rank order among regions from highest to lowest.

Data is from hospitals' financial disclosure reports to HCAI for 2021 through 2023.

Why Do These Findings Differ from Other Results? The analysis above fails to find consistent and clear positive relationships between market power and reimbursement levels. This finding contrasts with some, but not all, research on this topic. Key features of CHA's analysis, which may illuminate why these findings differ from others, include:

- Inclusion of reimbursement from all payers, rather than just a relatively small set of commercial payers (as in the RAND analysis presented at the August board meeting)
- Use of publicly available data for all California general acute care hospitals, as opposed to non-public data samples that are difficult to validate
- Regional delineation consistent with OHCA's regions, rather than using, for example, metropolitan service areas (MSAs) or Medicare core-based statistical areas
- A simplified approach that considers how one variable (concentration) relates to a second (reimbursement levels for all payers, adjusted to account for volume, service mix, and patient acuity), instead of the sometimes-complicated quantitative methods used in other studies that are difficult to assess for reasonableness

These differences between CHA's approach and others are discussed in greater detail in the Appendix at the end of the letter.

Premature to Adopt Sector Targets

OHCA's founding statute was intentionally crafted to facilitate iterative learning and process improvement. Data collection and analysis comes first. Spending targets follow. The spending target initially is statewide and unenforceable. Later, OHCA is to enforce the spending target and differentiate the health care field into sectors. Enforcement is to start with conversations with health care organization leaders and technical assistance, then move to performance improvement plans and, potentially, financial penalties.

The August board meeting featured calls to push ahead toward sector targets, contravening the clear intent in statute to learn from experience under the statewide spending target before applying different targets to different types of health care entities or regions. To answer such calls, at this point, would be premature, coming before OHCA has analyzed even baseline spending data, finalized a multipronged data collection plan, implemented the state's first spending target, or set any rules for enforcement. Moreover, OHCA has yet to consider how different sector targets for different components of the health care industry would interact. Before moving ahead, OHCA must consider whether a lower spending target for providers would allow payers to retain the resulting savings as higher earnings — or whether those savings must be passed through to consumers in the form of correspondingly lower payer targets Clearly, more groundwork is needed before moving forward.

Opportunities to Bend the Cost Curve for Hospital Care

Hospitals strive to make care more affordable for all Californians. Below are some areas for OHCA to explore to meaningfully improve affordability without sacrificing equitable access to high-quality care.

- **Improve the Care Transition Process.** Every day, thousands of patients are stuck in hospitals with nowhere to go. Their acute care needs have subsided, but coordination problems arise, resulting in delayed transitions to less costly and more appropriate post-hospital care. Addressing the problems in the care transition process, which have exploded since the onset of the COVID-19 pandemic, could bring substantial savings while simultaneously ensuring that patients are treated in the most appropriate setting for their conditions.
- **Help Health Care Professionals Do What They Do Best – Care for Patients.** Clinicians spend ever-increasing time on administrative work rather than treating patients. Every year, hospitals must hire more and more staff to navigate the opaque and evolving thicket of health plan policies and procedures that increasingly serve as barriers to appropriate care. OHCA should explore these issues and encourage policies and practices to improve the care authorization process.
- **Grow the Workforce.** Recruiting and retaining a highly skilled workforce is a longstanding challenge for hospitals and other health care providers, only made worse by the wave of departures from the health care workforce under the stresses of the COVID-19 pandemic. Researchers from the University of California San Francisco project nursing shortages until almost the end of the decade. Workforce shortages raise the price of labor, often forcing hospitals to rely on expensive contract labor (travelers), increasing costs while reducing access to care. OHCA should investigate ways to expand the health care workforce both throughout the state and in underserved areas by studying and supporting efforts to expand the education pipeline, ensure health care workers are able to practice at the top of their license, and that incentives are in place for practitioners to work where they are most needed.
- **Improve Access to Primary and Preventive Care.** Preventing disease onset and stopping its progression before it becomes acute is both better and more cost-effective care. Access to primary and specialty care is inadequate for too many Californians, resulting in expensive hospital stays for conditions that could have been treated earlier. OHCA is setting goals aimed at

encouraging greater investment in primary and behavioral health care. Going forward, OHCA must ensure these goals become a reality and yield tangible improvements in access for all Californians.

- **Further Protect Patients from the Financial Risks of Medical Conditions and Emergencies.** Health care spending is far from evenly distributed. A person may go decades with minimal health care use, only to need thousands of dollars in care following a medical emergency or serious diagnosis. Unfortunately, these costs increasingly are pushed onto patients in the form of higher deductibles and coverage denials. The end result: healthy people pay marginally less for coverage while the sick incur sometimes outsized medical expenses, creating disparities in the costs of care based on health status. OHCA should examine health insurance companies' marketing of plans that shift costs onto patients and encourage efforts to ensure that health care coverage is meaningful for those who need it most. Ultimately, coverage is not just a means to improve people's health — it is a critical financial protection. This was the most eye-popping finding of this century's landmark study on the effects of coverage expansion. While the study, known as The Oregon Experiment, found somewhat minimal effects of expanded coverage on short-term health outcomes, it found that the expansion virtually eliminated catastrophic out-of-pocket medical expenses, showing the potential for comprehensive coverage to protect against the downside financial risks of serious health conditions and medical emergencies.
- **Encourage Care Delivery Innovations.** To fulfill Californians' health needs, the care provided tomorrow cannot be the care provided today. New care delivery models are needed to treat patients in the least restrictive setting possible, such as under Hospital at Home and the nursing home diversion efforts under CalAIM. New technologies must be embraced, such as whole genome sequencing under Project Baby Bear to diagnose and treat newborns with serious health conditions. High-cost but potentially high-value treatments, like semaglutide (Ozempic and Wegovy) to reduce obesity and diabetes, should be available to patients who need them. More resources should go to underserved Californians to address longstanding inequities in access and care. All these improvements will require upfront investment. By capping the resources available to health care entities, OHCA risks obstructing, rather than encouraging, such innovations, locking in the health care system of today at enormous cost to the patients of tomorrow. To avoid this, OHCA must encourage new ways of providing care. To do so concretely, spending on improving access and quality cannot be penalized under the spending targets. And separately, OHCA and its board should encourage evidence-based practice transformations that ultimately improve patients' experiences and outcomes.

Urge Greater Balance in the Information and Perspectives Considered

OHCA has tremendous authority to shape the future of health care delivery and financing in California. To wield this power effectively — without serious unintended consequences for patients — a strong understanding of the workings of the health care sector is needed. OHCA board meetings present an incredible opportunity to build common understanding and work through the complexity of the questions and tasks before us. Unfortunately, the lack of balance offered at the August board meeting challenged, rather than supported, this prerogative — at times painting a misleading and reductive picture of the obstacles to providing affordable care for Californians. Going forward, hospitals urge the OHCA board to renew its commitment to inclusivity and balance in the issues, perspectives, and information that are explored.

Sincerely,

Ben Johnson
Group Vice President, Financial Policy

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

Appendix

The analysis shared in this letter found no positive relationship between market concentration and hospital reimbursement levels. The findings differ from other studies. Below are some of the ways this analysis differs from others, which may shed light on the benefits and drawbacks of this versus other approaches of studying this important question:

- **Which payers are included?** The analysis above includes the three major payers: commercial, Medi-Cal, and Medicare. Other analyses focus on commercial payers, ostensibly because prices are universally negotiated as well as highest in the commercial space. However, while there are unique considerations and constraints, pricing negotiation is present in Medi-Cal and Medicare managed care, through which more than 90% of all Medi-Cal beneficiaries and around 50% of Medicare participants receive coverage. Moreover, using the major payers captures overall reimbursement for hospitals, thereby accounting for differences in hospitals' revenue generating strategies and capacities. For example, high Medicare Advantage hospitals may focus their negotiating efforts on obtaining relatively higher prices from Medicare Advantage plans, with less emphasis on their commercial book of business.
- **What data is used?** The above analysis relies on comprehensive financial reporting from hospitals to the Department of Health Care Access and Information. It covers:
    - All general acute hospitals operating in California
    - Total net patient revenue for all inpatient and outpatient services for the three major payers divided by the sum of discharges for inpatient and discharge-equivalents for outpatient, risk-adjusted using the case mix index
    - The years 2021 through 2023 to smooth out annual anomalies often present in these data.

  Other analyses use other sources of data. For example, the analysis presented by Dr. Whaley at the August board meeting used a dataset for California comprising voluntarily reported commercial pricing data covering, at most, 10% to 15% of Californians.
- **How are regions delineated?** This analysis looks at market concentration regionally based on the OHCA regions, with the lone exception of Los Angeles being consolidated into a single region. For more densely populated areas, the regions are counties. For less dense areas, groups of counties are aggregated into a single region. Other similar analyses break geography up differently, such as by metropolitan service area (MSA) or hospital referral region. Ultimately, researcher decisions on how to delineate geography may have major implications on the results. To test this, CHA instead performed an identical HHI analysis by MSA, obtaining the same result showing no positive relationship between concentration and reimbursement.
- **What are the studies' methodologies?** Different studies use different approaches for identifying the influence of market concentration on prices. CHA's analysis looked simply at the basic two-way relationship between these factors, finding no evidence that the former is determinative of the latter. However, other factors like household incomes, age patterns, and population density may influence this relationship. Some approaches aim to account for these other factors, such as by incorporating demographic information or alternatively controlling for overall differences across regions. Unfortunately, the methods of such studies can quickly get complicated, are often the end result of significant experimentation by researchers when it comes to model specification, and sometimes are not transparent, ultimately making it impossible to ascertain the reasonableness of the methods' assumptions and specifications.[3] Sometimes, simple is better.

[3] See, for example, the dearth of detailed information provided on the methods used to estimate the relationship between prices and market share (page 17) in the RAND Research Report: Prices Paid to Hospitals by Private Health Plans, Findings from Round 5 of an Employer-Led Transparency Initiative (link).

HEALTH ACCESS CALIFORNIA

October 10, 2024

Sandra Hernandez, M.D., Vice Chair
Health Care Affordability Board

Kim Johnson, Member
Health Care Affordability Board
Secretary, California Health and Human Services Agency

Elizabeth Landsberg, Director
Department of Health Care Access and Information

Vishaal Pegany, Deputy Director
Office of Health Care Affordability

2020 W. El Camino, Ste 1200
Sacramento, CA 95833

Re: October 2024 Health Care Affordability Board Meeting

Dear Dr. Hernandez, Ms. Johnson, 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 and proposals for the October 2024 Health Care Affordability Board meeting:

- Affordability for consumers and other purchasers connects to rate review.
- Definition of sectors: Health Access proposes that the Office and the Board look at the top 10% or 20% of high-cost outliers, with commercial prices expressed as a percentage of Medicare.
- Primary care benchmark recommendations: Support staff recommendation on 15% of spending.
- Behavioral health benchmark: unmet need, misaligned resources for California consumers.
- Hospital spending measures: inpatient and outpatient, facility and system: we discuss the importance of accurately capturing both inpatient and outpatient revenues and looking at health systems as well as individual facilities.

Rate Review and Affordability for Consumers and Other Purchasers

The Office of Health Care Affordability and the Health Care Affordability Board are intended to improve the affordability of health care for consumers and other purchasers by slowing the rate of growth of health care costs. The Board and staff have taken an important first step by setting cost growth targets based on median family income over the last twenty years. The trailer bill, S.B. 184 that contains both OHCA and law connecting rate review by DMHC and CDI[1] to the cost growth target was designed to connect the OHCA cost targets to rate review so that consumers and other purchasers could benefit from. "Rates" by definition includes both premiums, share of premium, and cost sharing such as deductibles, copays, coinsurance and maximum out of pocket limit.

[1] Health and Safety Code 1385.035, parallel section in Insurance Code

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We continue to urge the Office and the Board to track measures of consumer affordability, including premiums, worker share of premium, deductibles and other cost sharing as well as consumers forced to spend out of pocket for behavioral health that should be a covered benefit. Tracking measures of consumer affordability is a necessary but not sufficient step to impact actual affordability. Both prevalence and amount matter: for instance, twenty years ago only one in three California workers had a deductible, today 80% or more of workers with employer coverage have a deductible.

To impact affordability requires linking the OHCA cost targets to the rate review process for health plans and insurers. Health Access proposes that the cost targets inform the rate review process for the overall rate increase as well as those elements of covered benefits that are subject to the cost growth targets. These elements include hospital costs, physician organizations, labs and imaging. The elements map to the benefit categories included under existing law include hospital inpatient, hospital outpatient, professional services, other medical, capitation expenses, lab and imaging as well as administration and profits (or revenues in excess of expenditures for non-profits). These benefit categories constitute about 80% of the spending on rates, depending on the health plan[2].

We look forward to working closely with the Office and the two regulators, the Department of Managed Health Care and the Department of Insurance, to hold the growth of rates to a level that is not unreasonable and not unjustified[3].

Definition of Sectors: High-Cost Outliers

This is the third letter in which we offer a discussion of how to define "sectors". In the letter submitted prior to the Board meeting in Monterey, we offered an overview, including a review of the enabling statute[4]. In a separate letter submitted after the Monterey Board meeting and prior to the October 14, 2024, Board meeting, we focused on the three Monterey hospitals, proposing a target of 0.1% growth for those three outlier hospitals. Here we extend and broaden the discussion by looking statewide and beyond hospitals.

Health Access proposes that OHCA conduct analyses of high-cost outliers for hospitals, physician organizations, and other types of entities across California, primarily using data from the Health Payments Database data. Other data sets and analyses can help to confirm these findings, as was done for the Monterey hospitals. We propose approaching high-cost outliers by looking at the top 10% or 20% of commercial prices, expressed as a percentage of Medicare. OHCA may also consider high-cost outliers that have costs in the top 10% or 20%, after adjusting for age, sex and in some cases, health status[5] of the consumers served.

In the future, we will discuss health plans and insurers. Here we focus on the costs that comprise the "medical losses" in the medical loss ratio.

Why the Top 10% or 20% of High-Cost Outlier Commercial Prices?

Why prices? Because for commercial coverage, "it's still the prices, stupid" that drive spending[6]. Costs for the segment of "total health care expenditures" that is commercial coverage rather than Medicare or Medi-Cal are driven by the price for care. A broad literature now demonstrates this as does the case study of the three Monterey hospitals.

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[2] The only benefit category excluded from the OHCA targets at this time is outpatient prescription drugs.
[3] The double negative of "not unreasonable" and "not unjustified" are the terms of art in rate review and rate regulation.
[4] https://hcai.ca.gov/wp-content/uploads/2024/09/June-2024-OHCA-Board-Public-Comment.pdf pp. 17-29. Please also see the Berkeley Labor Center letter at pp. 11-16.
[5] With respect to health status, we do not propose full risk adjustment, but we do recognize that some entities, such as cancer centers or Rancho Los Amigos, treat sicker patients than community hospitals.
[6] Reinhardt et al and later piece by Anderson et al: https://www.healthaffairs.org/doi/10.1377/hlthaff.22.3.89 and https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05144

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The law refers repeatedly to "high-cost outliers". We recognize that "cost" and "prices" are two different things: that is why we suggest using a percentage of Medicare, because Medicare rates are intended to be sufficient for an "efficiently run" hospital or physician organization. In contrast, commercial prices are not tethered to costs but instead encourage cost growth. Entities that make more spend more as a general rule.

The five rounds of the RAND Hospital Price Transparency study indicate that there is a broad range of hospital prices paid by commercial payers, expressed as a percentage of Medicare[7]. What the five rounds of the RAND study demonstrate is that even within the same geographic region for the same services, market power allows highly differential prices to commercial payers[8]. Other studies, much of it surrounding the Sutter anti-trust litigation, indicate variable prices for the same procedure across geographic regions[9]. Some national studies even indicate that the same hospital is paid a different commercial price by different commercial payers for the same procedure. The Federal Trade Commission found that "prices for medical services vary within hospitals and vary more across them"[10]. The Congressional Budget Office had similar findings[11].

What is a High-Cost Outlier?

The answer to what is a high-cost outlier commercial price, expressed as a percentage of Medicare, may vary by provider type. Because of the range of variation for physician organizations may be different than that for hospitals or other entities, our proposal is that OHCA look at the top 10% or 20% of commercial prices for types of entities, expressed as a percentage of Medicare.

Reviewing the RAND data for California, for hospitals, we would posit that today, as a rule of thumb, a hospital being paid more than 400% of Medicare by commercial payers is likely a high-cost outlier hospital that should be subject to a lower cost growth target[12]. Other analyses such as that by Board Member Kronick and others on hospital costs using HCAI data show a similar range of hospital costs as the RAND studies[13].

The range for physician organizations and other services may be wider or narrower. Some of the data we have seen, such as that presented at the Monterey meeting and a review of literature by the Congressional Budget Office, suggests that physician services generally are both a lower percentage of Medicare and a narrower range of prices[14]. Conversely, other data such as that presented during the national debate over surprise medical bills that culminated in the No Surprises Act suggests that some physician specialties can be paid a very high percentage of Medicare by commercial payers, such as anesthesiologists charging as much as 800% or 1,100% of Medicare[15]. Surprise medical bills was another example of the use of market power to increase commercial prices.

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[7] https://www.rand.org/health-care/projects/hospital-pricing.html

[8] This series of analyses is limited in various ways: it is only hospitals, though both inpatient and now outpatient; the analyses are based on a subset of commercial claims, particularly in California where it does not include the 13-15 million Californians enrolled in state-licensed coverage; and it suppresses hospitals with a small number of claims.

[9] Scheffler et al.

[10] https://www.ftc.gov/system/files/documents/reports/prices-medical-services-vary-within-hospitals-vary-more-across-them/working_paper_339.pdf and https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01476

[11] https://www.cbo.gov/system/files/2022-09/58222-medical-prices.pdf and https://www.cbo.gov/system/files/2022-01/57422-medical-prices.pdf

[12] https://www.rand.org/health-care/projects/hospital-pricing.html

[13] Kronick and Neyaz: https://westhealth.org/resources/private-insurance-payments-to-california-hospitals-average-more-than-double-medicare-payments. This data shows a somewhat lower range, we suspect in part because that analysis is based on data almost a decade old

[14] CBO

[15] Loren Adler? While in-network providers are often paid a contracted rate that is often not based on "charges" or sticker price, an out of network doctor or hospital such as those involved in surprise medical bills or emergency care often expect to be paid billed charges.

Other examples of market power, such as specialty physician organization in a city such as Redding or a dominant market player such as a non-Kaiser specialty physician organization in the East Bay exist with respect to physician services and likely other services. Whether it is physician organizations or labs and imaging, price will vary, depending in part on market power and negotiating ability.

Why Start with Hospital Costs and Hospital Prices?

Hospital costs, inpatient and outpatient, amount to the largest share of the premium dollar for commercial coverage, about 40%-50% of the costs included in commercial rates[16]. Hospital costs are also an important part of the cost of Medicare and Medi-Cal but for commercial coverage for the under-65 population, hospital costs loom especially large[17]. Hospitals, including both individual hospitals such as the three in Monterey and hospital systems, have been able to use market power to obtain higher commercial prices.

Data on other settings and services has lagged data on hospital costs. But with the advent of the HPD, such data should be more readily available.

Why the Health Payments Database Data?

Health Access proposes that the Office use the data on prices currently in the Health Payments Database (HPD) to analyze high-cost outliers. The HPD, developed and maintained by the Health Care Access and Information Department (HCAI), includes prices paid to cover care for 75%-80% of all commercially insured lives in California[18]. This includes the 13-15 million state-regulated commercially insured lives plus another one to two million lives[19]. The HPD contains data on the self-insured lives for state and local government employees subject to state regulation, such as those covered by CalPERS and those school employees similarly under a provision of the Knox-Keene Act[20].

The HPD data is available to HCAI and should be available to OHCA to allow it to conduct analyses of high-cost outliers. In addition, analyses done earlier by Board Member Kronick[21], using HCAI data, could be replicated to help confirm the results. The RAND hospital price studies also are useful and have expanded to include outpatient as well as inpatient for a majority of California hospitals.

Why Commercial Prices Expressed as a Percentage of Medicare Rates?

Medicare rates are adjusted for case mix and local costs, such as wages, and cover a broad range of hospital, physician and other services. Expressing commercial prices as a percentage of Medicare rates allows ready comparison across payers, geographic regions and entities. For most care and most providers, Medicare rates account for the elements of cost needed to provide care efficiently with a modest profit. Relying on Medicare rates as a baseline allows comparison across payers as well as among providers.

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[16] For example, the Blue Shield filing for individual rates for 2025 and the Anthem filing for small group for Oct. 1, 2024, allocated 42%-45% of rates to hospital inpatient and outpatient claims. In contrast, the benefit category of professional services was about 20%-24% of the rate. Source: DMHC rate review filings. Author calculation.

[17] Unlike Medicare and Medicaid, commercial coverage generally does not include long term care services and supports. Hospital costs are about 37% of national health expenditures: "Hospital prices are likely a significant factor in these higher premiums given that hospital care made up approximately 37% of private health insurance expenditures in the U.S. in 2021: U.S. Center for Medicare and Medicaid Services, National health expenditures data - Historical.

[18] The HPD is actively adding other self-insured lives subject to DOL regulation. We also note

[19] Counts of enrollment vary somewhat over time and by data source. https://www.chcf.org/publication/ca-health-insurers-enrollment-2023-edition/

[20] Health and Safety Code 1349.2.

[21] https://westhealth.org/resources/private-insurance-payments-to-california-hospitals-average-more-than-double-medicare-payments.

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Some adjustments to Medicare rates may be in order. For example, although Medicare covers people under age 65 with severe disabilities and thus women's and children's care, some adjustment for pediatric care as well as obstetrics and gynecology and labor and delivery may be appropriate. Using the Medicare data more extensively at the state level may indicate a need for California-specific adjustments, given the suspected rural-state bias of some national programs.

Health Access Proposes that High-Cost Outliers are The Top 10% or 20% of Entities, with Prices Expressed as a Percentage of Medicare

Health Access proposes that the Health Care Affordability Board impose lower cost growth targets on those entities with commercial prices in the top 10% or 20% of commercial prices and that OHCA use the HCAI HPD data, and other data sources as appropriate, to analyze prices paid by commercial payers as a percentage of Medicare. For those high-cost outliers, we propose lower cost growth targets until such time as their prices come into line with other entities of the same type.

These proposals add to, and extend, our proposal that the three Monterey hospitals be subject to a 0.1% cost growth target, in recognition of their clear status as high-cost outliers based on multiple data sets and analyses. Our proposal on Monterey stands. Health Access urges the Board and the Office to move promptly with targets specific to the three Monterey hospitals. Prompt action is justified to make improvements for consumers in Monterey and to begin to shift the dialogue around health care costs toward the triple aim of better affordability, improved outcomes and greater equity. Health Access also proposes that staff with Board input begin conducting additional analyses to determine what other high-cost outliers should be subject to lower cost growth targets. If it is possible set lower cost growth targets for a broad range of high-cost outliers by June 1, 2025, we support that.

Primary Care: 15% Benchmark

Health Access supports the staff recommendation of increasing spending on primary care by setting the proposed benchmark at 15% of total medical expenditures by 2034 as a critical step in creating a well-functioning health system[22]. Health Access supports the staff recommendation excluding urgent care and retail clinics from the definition of primary care: today consumers are forced to turn to these resources because of the lack of timely access to adequately funded primary care. The primary care benchmark should be the goal that we are proceeding toward, not a measure of the current dysfunction.

With respect to the inclusion of obstetricians and gynecologists, who provide important care for women and other persons, Health Access supports the earlier staff recommendation that excludes obstetricians and gynecologists unless those practitioners provide the majority of care for acute and chronic conditions. Put more simply, if a woman relies on an OB-GYN to screen and treat asthma, diabetes, hypertension, depression and heart disease, if it is the OB-GYN, you call when you think you have COVID or a weird rash, then the OB-GYN is a primary care provider. And if not, then not.

Behavioral Health: Unmet Need, Current Spending Maldistribution

The investment and payment workgroup has begun the discussion about a benchmark or benchmarks for behavioral health. While the law points to current spending on behavioral health as an initial measure, that step is necessary but not sufficient given the widely acknowledged unmet need and lack of access to timely and appropriate care, including early intervention and other preventive measures for behavioral health. This Administration has taken important steps forward on a path to providing consumers what they need in terms of behavioral health, but we are still a long way from that goal. For example, today all too often consumers turn to emergency rooms because of lack of adequate access to timely behavioral health services. In many

[22] https://hcai.ca.gov/wp-content/uploads/2024/07/June-2024-OHCA-Board-Meeting-Presentation.pdf

instances, using the emergency room for behavioral health intervention is as inappropriate as managing asthma or diabetes in the ER: people's care should be better managed than that.

As with primary care, the task ahead is to imagine a better world in which Californians get the care they need when they need it to stay healthy and be well functioning. As expected by some of us, the task of sorting out what this looks like for behavioral health is more complex and daunting than for primary care. Where we are is not where we should be; that is easy to agree on. Figuring out where we should go in terms of behavioral health is a bigger challenge and may require iteration over time.

Hospital Spending: Inpatient, Outpatient, Systems as well as Facilities

Health Access supports the work of the Office to accurately capture and characterize hospital spending and revenues. Two key elements frame our work in this area:

First, some parties have questioned efforts to include or improve reporting on public funding streams or other significant revenue streams. Net patient revenue alone may not be sufficient to encompass even spending on inpatient care. From a consumer perspective, virtually every dollar in health care starts in a consumer's pocket, as a taxpayer, an employee, someone with health coverage or without:

- As taxpayers, we pay for Medicare, Medi-Cal, and Covered California subsidies, either directly or through the employer share which could otherwise be spent on our wages.
- As employees or dependents of employees, employers pay health benefits as part of compensation, compensation that could otherwise go to increased wages.
- As employees or individual consumers, we pay share of premium as well as cost sharing such as deductibles, copays, and coinsurance.

Second, the HCAI financial reporting on hospitals and other facilities was created about fifty years ago. Some of the approach is dated, no longer accurately reflecting how care is delivered today. Other elements are inconsistently reported, for whatever reasons. And there are major gaps, such as reporting on health systems.

From a consumer perspective, it is important to capture all of the spending on hospitals and hospital systems regardless of how it flows through the health system because virtually all of it originates with the consumer. It is our money, and we want to know how it is spent.

Inpatient Hospital Revenues and Spending

Health Access has had a number of questions about elements of hospital revenues such as the hospital provider tax, known as the Quality Assurance Fee (QAF); disproportionate share hospital funding (DSH); and other public funding streams. It is not clear whether these significant funding streams are reported, and it also appears that there may be inconsistency in reporting on these funding streams. Eliminating or minimizing these inconsistencies to capture a full picture of taxpayer-financed revenues to hospitals will provide important information. Conversely, some revenue streams, such as gift shops, are probably not significant revenue contributors. Updating the HCAI health facility reporting to reflect current revenue streams as well as to minimize inconsistencies in reporting will create a more solid data foundation moving forward.

Outpatient Financial Reporting

Fifty years ago, hospital outpatient care was a small fraction of total hospital spending because most care was provided inpatient with patients staying overnight, sometimes for lengthy periods of time. Now data from health plan rate review suggests that hospital outpatient claims roughly equal inpatient spending.

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Because the existing data reporting was created in another era in terms of care, it omits important information on outpatient care and spending. This appears to be information that most hospitals collect and are able to report.

Staff proposed as one option imputing outpatient spending allocations based on inpatient spending, but this is likely to create an inaccurate picture because hospitals vary in the ratio of inpatient to outpatient care and because the dominance of managed care for both Medi-Cal and commercial coverage makes some approaches using fee-for-service claims data misleading. A better solution is to collect the information on hospital outpatient care, now a spending segment as important as inpatient care.

Similar to the discussion about imputing outpatient spending based on inpatient spending, risk mix for outpatient care is very different than risk mix for inpatient care. Finding the right measures to address risk mix for outpatient care is part of the challenge ahead and something under discussion.

Systems as well as Facilities

In the 1970s and 1980s when the Office of Statewide Health Planning and Development (OSHPD), HCAI's predecessor, was created, aside from the Kaiser hospitals, most hospitals were stand-alone entities. In our experience, in those years, sometimes even those hospitals that were nominally parts of systems did not function as parts of systems. Over the decades since, not only have dozens of California hospitals become part of larger health systems, but the systems themselves have transformed to function more as systems: centralizing various functions and, of particular importance in terms of OHCA's mission, holding reserves and profits at the system level rather than leaving the money in the individual facilities.

Unfortunately, the HCAI facility financial data reporting has not kept up with this evolution in the health care landscape. It is time, and past time, for it to do so. Health Access supports collecting financial information at the system level, knowing that to do so will require work to define "system level". In the meantime, in targeted situations such as the Monterey hospitals, we have encouraged the Office to use its authority to collect not only audited financial statements but also statements of financial position that reflect reserves, various accounts and assets to give a picture of the resources of each of these entities.

Summary/Conclusion/Key Points

First, to impact actual affordability for consumers and other purchasers requires linking the cost growth targets to rate review by DMHC and CDI as well as potentially contracting by Covered California and CalPERS.

Second, with respect to the definition of sectors: Health Access proposes that the Office and the Board look at the top 10% or 20% of high-cost outliers for types of entities, with commercial prices expressed as a percentage of Medicare.

Third, on the primary care benchmark recommendations, Health Access support staff recommendations including that 15% of total medical expenditures be spent on primary care.

Fourth with respect to developing behavioral health benchmark or benchmarks, the realities of unmet need, misaligned resources and a complex delivery system of behavioral health services and care for California consumers means that the task of developing benchmarks for behavioral health is more complicated than that for primary care.

Fifth, on hospital spending measures, we discuss the importance of accurately capturing both inpatient and outpatient revenues and looking at health systems as well as individual facilities.

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We look forward to continuing to work with the Board and the staff of the Office as these discussions move forward.

Sincerely,

Beth Capell, Ph.D.
Policy Consultant

Amanda McAllister-Wallner
Interim Executive Director

CC: Health Care Affordability Board
Kimberly Chen, Acting Deputy Secretary, Program and Fiscal Affairs, California Health and Human Services Agency
Darci Delgado, PsyD, Assistant Secretary, California Health and Human Services Agency
Mary Watanabe, Director, Department of Managed Health Care
Josephine Figueroa, Deputy Commissioner, Department of Insurance
Assemblymember Robert Rivas, Speaker of the Assembly
Senator Richard Roth, Chair, Senate Health Committee
Assemblymember Mia Bonta, Chair, Assembly Health Committee
Senator Caroline Menjivar, Chair, Senate Budget Subcommittee on Health and Human Services
Assemblymember Akilah Weber, M.D., Chair, Budget Subcommittee on Health

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October 10, 2024

Members of the Office of Healthcare Affordability Board
2020 W. El Camino Avenue
Sacramento, CA 95833

Sent via email.

Subject: August 28, 2024 Office of Healthcare Affordability Board Meeting

Dear members:

On behalf of Montage Health's Board of Trustees, physicians, nurses, staff, and our community partners, we respectfully submit this letter in response to the recent OHCA Board meeting held in Monterey on August 28, 2024. We acknowledge the concerns raised regarding healthcare costs in Monterey County, which, like many communities across California and beyond, face significant challenges in maintaining affordability while ensuring high-quality care. We share the belief that decisive steps must be taken to make healthcare more accessible and affordable for all members of our community.

However, we respectfully wish to express our concern that much of the information presented during the meeting lacked important context and did not adequately reflect the perspectives of the healthcare providers directly serving patients in Monterey County. In light of this, we would like to offer our perspective and additional context.

We believe the data presented at the August meeting did not account for Montage's payer mix, particularly our significant Tricare population, which may have been inaccurately categorized as commercially insured. This distinction is important, as it impacts the overall understanding of the challenges we face.

Below, we outline some of the key factors driving healthcare costs in Monterey County and the actions we are taking to address these challenges:

- **Hospital Structure and Capacity:** Monterey County has four independent hospitals with a combined total of 678 licensed beds, offering one bed per 645 residents—placing us in the median range for California counties. Our hospitals operate independently and face robust competition. Only 18 other counties in California have four or more independent hospitals, underscoring the unique landscape in which we operate.

- **Labor Costs:** The largest expense for hospitals in Monterey County is personnel. To attract and retain high-quality caregivers and support staff, we pay 26% above the state's average hospital wage, and our evening and weekend differentials surpass those of many Bay Area hospitals.

Labor expenses account for 61% of our total costs, 7% higher than the state average. Any significant reduction in expenses would likely result in job losses and lower wages for our 3,300 dedicated team members.

- **Payer Mix and Community Needs:** As mentioned, Montage Health serves a community where 49% of residents are covered by Medi-Cal, a figure 10% higher than the state average. Additionally, we care for every patient, regardless of their ability to pay, which further compounds the financial pressures we face.

- **Integrated Healthcare System:** It is critical to recognize that Community Hospital is not an isolated entity, but rather the core of an integrated delivery system that supports essential healthcare services across our region. Over the past decade, we have faced a collapse in primary care practices in Monterey County. In response, we formed Montage Medical Group, which now employs over 100 clinicians, including specialists in neurology, urology, infectious diseases, vascular surgery, and critical care—areas where there would otherwise be no providers on the Monterey Peninsula. To sustain these vital services, Montage Health absorbs an annual loss of over $35 million at Montage Medical Group. In addition, we subsidize millions of dollars annually to maintain Ohana, the county's only transformative mental health campus and programming for children, adolescents, and parents. We also cover the cost of all of our population health work which focuses on diabetes, chronic illnesses, and more.

Despite these challenges, we are committed to reducing healthcare costs and have already taken several steps toward that goal:

- We established the Montage Health Fund for Teachers at the Community Foundation for Monterey County, contributing $5 million to provide direct, non-taxable cash awards to every teacher in the county.

- We eliminated $42 million in outstanding COVID-era medical debt, benefiting over 26,000 households in our community.

- We negotiated a contract with one of the county's largest employers, resulting in over $1 million in annual savings, with hopes that these savings will be passed on to their employees.

- We have offered similar discount packages to local unions and the Joint Powers Authority, representing teachers and municipalities, but unfortunately, these offers have not yet been accepted as of this writing. In total, these packages offer **a combined $3.5 million in recurring savings to these members.**

Furthermore, we are implementing a **Community Affordability Initiative**, with a target of reducing $50 million in expenses by the end of 2026. We are also voluntarily capping price increases at 3.5% for 2025, aligning with OHCA's targets for 2026.

We recognize that other healthcare organizations in California face similarly challenging environments, including high costs of living and difficult payer mixes. However, we believe the confluence of these factors in Monterey County—combined with the need to underwrite ambulatory services—creates a unique set of challenges that is not fully comparable to other regions.

If the OHCA Board is aware of other healthcare systems managing similar challenges at a lower price point while maintaining sustainable margins, we would welcome the opportunity to learn from their experiences. In the meantime, we respectfully urge the Board to consider the broader context and the

complex realities faced by healthcare providers in Monterey County. We hope that the OHCA will work collaboratively with organizations like ours to develop practical and sustainable solutions to these issues, rather than focusing on a singular narrative in addressing such a multifaceted problem.

Thank you for your time and consideration of our perspective.

Sincerely,

Steven Packer, MD
President and CEO, Montage Health