California Pushes Ahead the Office of Health Care Affordability with Renewed Budgetary Support

Healthcare costs have grown exponentially in California[1], and Californians have indicated that it is a core issue they want the Governor and Legislature to address and remedy. In a 2021 poll, Californians expressed almost unanimous demand for action, as 82% of Californians said it is "extremely" or "very" important for the Governor and Legislature to make health care more affordable.[2] While rising healthcare costs seem to be a national problem, Californians pay more for common health services than the rest of the country, with an additional cost disparity between northern and southern California.[3]

To combat the pressing issue of rising health care costs, in 2021, Assemblymember Jim Wood introduced AB 1130, which would establish the Office of Health Care Affordability (OHCA and/or the office) to control health care costs while ensuring high quality care.[4] The Governor recently re-proposed—through the 2022-23 budget proposal and corresponding trailer bill—establishing the OHCA within the Department of Health Care Access and Information (HCAI). According to the HCAI, "the Office of Health Care Affordability will be charged with analyzing the health care market for cost trends and drivers of spending, creating a state strategy for controlling the cost of health care and ensuring affordability for consumers and purchasers, and enforcing cost targets."[5] In this post, we briefly examine the history of state cost commissions and California's attempt in establishing the OHCA, detail the key components of Governor Newsom's recent 2022-23 Budget Proposal and extensive trailer bill language outlining specifics of the

OHCA, and discuss potential roadblocks and limitations for the potential OHCA and what to expect next.

History of State Healthcare Cost Commissions

The proposal of a healthcare cost commission is not a novel idea. Several other states have passed similar legislation establishing independent offices or cost commissions to address healthcare affordability and contain health spending within their state.[6] To achieve the goal of controlling healthcare costs, these entities perform various functions, including setting healthcare cost targets and penalties on healthcare entities that do not meet such targets; establishing incentives to encourage and adopt payment models based on quality of care rather than only costs; and collecting comprehensive data on financial information from health care payers and providers.[7]

States including Massachusetts, Delaware, Rhode Island, Oregon, Connecticut, Washington, Nevada, and New Jersey all have entities that work towards controlling healthcare costs. In 2020, for example, Washington state enacted HB 2457 establishing the Health Care Health Cost Transparency Board to increase transparency and reduce health care expenditures and growth in the state.[8] To achieve this goal, the Washington Board has a number of responsibilities, including determining the state's total health care expenditures; identifying cost trends and drivers; setting health care cost growth benchmarks and reporting requirements for providers and payers; and annual reporting to the legislature of best practices and recommendations to lower health care costs.[9] More recently, Oregon established the Sustainable Health Care Cost Growth Target Program (SB 889 (2019) and HB 2081 (2021)) to ensure health care costs do not outpace wages or Oregon's economy. Oregon's program sets health care cost growth targets for annual per capita rate of total health care spending in the

state and sets accountability mechanisms—such as mandatory civil penalties—for failing to report or meet cost growth targets. Notably, Oregon and Massachusetts are the only state programs that impose mandatory penalties for noncompliance, which may be the best tool to ensure health care cost target compliance.

All the states' cost containment programs, with the exception of Massachusetts, are relatively new (established between 2018 and 2021)—thus comprehensive reviews of their effectiveness are not readily available. Massachusetts' Health Policy Commission (HPC) has been in place for about a decade, since 2012,[10] and studies have shown that with the efforts of the HPC, Massachusetts stayed within its state health care cost growth targets for the first several years of the HPC's implementation, but the state has exceeded its targets for two consecutive years since then.[11] Though cost targets are a popular mechanism that a handful of states have adopted, in implementing a healthcare cost target, California policymakers need to consider its efficacy—and all other mechanisms adopted by fellow states—in actually reducing health care costs long-term.

Establishing a Healthcare Affordability Office in California

Following the model of these states, California has looked to establishing a similar healthcare cost commission as both an executive and legislative goal in the past few years. California's proposed version may arguably be the most comprehensive as the proposal has been in development since 2020 and borrows from the experiences of others states.

Governor Newsom's Support for Health Care Affordability

Governor Gavin Newsom had long advocated for health care affordability even before taking office. During his gubernatorial candidacy, he vowed to address rising health

care premiums and significant medical bill costs that many Californians face.[12] Once in office, Governor Newsom has consistently supported, within the annual state budget, establishing an OHCA to help address health care affordability.

Newsom first proposed the establishment of the OHCA, to be housed within the California Health and Human Services, in the 2020-21 Budget Proposal, which included a $30 million one-time general fund to establish the office. However, the proposal was withdrawn due to the emergency of the COVID-19 pandemic.[13] The same budget proposal, supported by budget-related legislation (AB 80), also authorized the establishment of the Health Care Data Payments Program (HPD), California's all payer claims database (APCD). The HPD would collect data on health regarding health care costs, utilization, quality, and equity to provide transparency to the public and better aid policy decisions. According to the HCAI, "the information from the HPD System is intended to support greater health care cost transparency and will be used to inform policy decisions regarding the provision of quality health care, and to reduce health care costs and disparities. It is also intended for the information to be used to develop innovative approaches, services, and programs that may have the potential to deliver health care that is both cost effective and responsive to the needs of all Californians."[14] Though the HPD has yet to go live, it is mandated to be substantially completed by July 2023[15]; and according to the California Legislative Analysis Office, "the HPD is envisioned as a key component of the [potential] Office of Health Care Affordability."[16]

In the subsequent year, Governor Newsom again supported the creation of the OHCA, to be housed within the Office of Statewide Health Planning and Development (which was later reconstituted into HCAI), in his 2021-22 Budget Proposal, and the Legislature agreed the OHCA would collect, identify, and analyze trends in the health care market.[17] Specifically,

the final budget allocated a one-time General Fund sum of $30 million to establish the office and outlined a three-year plan for the office, with $11.2 million in 2021-22, $24.5 million in 2022-23, and $27.3 million in 2023-24.[18] Despite the 2021-22 budget proposal, no legislation has since passed to officially establish the OHCA.

Legislative Effort in Establishing an Office of Health Care Affordability

In addition to the Governor's efforts, a legislative proposal to create an OHCA was formally introduced in 2021,[19] when Assemblymember Jim Wood sponsored AB 1130, "a bill to create the OHCA, an entity that would collect and analyze the health care market for cost drivers and trends in order to develop data-informed polices for lowering and controlling health care costs, with the ultimate goal of providing quality and affordable health care to all Californians."[20] Under AB 1130, responsibilities of the office include creating and achieving health care cost targets for California, promoting a shift from fee-for-service payment methods to models encouraging high-quality and cost efficient care, and encouraging competition by diligently reviewing mergers, acquisitions, and other transactions constituting a material change. Payers, including all private and public health care payers, would be required to submit data to assist the office in measuring total and per capita health care expenditures and determining entities that do not meet the cost targets. The office would also be required to publish an annual report detailing its findings on health care spending trends and underlying factors (see Source Blog post for more details).

As with prior OHCA proposals, discussions on AB 1130 paused in late 2021 due to the State's more-immediate crises, including wildfires, COVID-19 and the Delta variant.[21] Despite all the Administration and Legislature's efforts, no policy or legislation has been enacted to establish the OHCA. However, all that may change with the Governor's 2022-23 Budget

Proposal and trailer bill language detailing the establishment of OHCA.

The Governor's 2022-23 Budget Proposal & Trailer Bill Supporting the OHCA

In January 2022, Governor Newsom released his 2022-23 Budget Proposal, which reappropriated the $30 million in funding for OHCA that was originally included in the 2021 Budget Act. Recently, following the 2022-23 Budget Proposal, trailer bill language—the California Health Care Quality and Affordability Act[22]—was submitted to potentially establish the OHCA. While the budget proposal is a crucial financial component that would support the establishment of the office, the trailer bill details the role and specific implementation of the office. The trailer bill is a lengthy 40 pages, which includes more fleshed out specifics for implementation of the office, the annual report, the board, and health care cost targets.

The Office

The proposal establishes the OHCA within the HCAI and indicates it "shall be responsible for analyzing the health care market costs trends and drivers of spending, developing data-informed polices for lowering health care costs for consumers and purchasers, creating a state strategy for controlling the cost of health care and ensuring affordability for consumers and purchasers, and enforcing cost targets."[23] The proposal also enumerates the multiple responsibilities of the office, including the following key responsibilities:

- Establishing a statewide health care cost target for per capita spending and specific health care cost targets by health care sector, and enforcing compliance with the targets;[24]
- Collecting and analyzing data from multiple private and public sources to track spending, set health care cost

targets, approve performance improvement plans for entities falling short of targets, and monitor impacts on health care workforce stability;
- Promoting, measuring, and publicly reporting health care entities'—healthcare service plans, health insurers, hospitals, and physician organizations—performance on quality and health care equity by adopting of a set of standard quality and equity measures;[25]
- Advancing standards for health care workforce stability, as they relate to costs;[26]
- Addressing various market trends through reviewing required cost and market impact reporting of consolidation involving health care service plans, health insurers, hospitals, physician organizations, pharmacy benefit managers, and other health care entities;[27]
- Advancing standards for adoption of alternative payment models rewarding high-quality and cost-efficient care over only fee-for-service payment;[28] and
- Promoting and measuring investment in primary and behavioral care to increase health care savings in the long run.[29]

Additionally, the proposal requires the office's collaboration with the Legislature and other state entities. Though the language requires the office to "be responsive to requests for additional information from the Legislature, including providing testimony during hearings and commenting on proposed legislation or policy issues,"[30] the proposal makes no other specific, consistent communication between the office and the Legislature. However, the proposal does require the office to coordinate with other state entities, such as with:

- the State Department of Health Care Services for health care data related to total health care expenditures for services paid for outside of Medi-Cal managed care plans and quality and equity measures to assess performance

for the Medi-Cal program; and
- the Department of Managed Health Care (DMHC) and the Department of Insurance for various information about health care service plans, such as information on premiums, cost sharing, and benefits.[31]

The Annual Report

By June 1, 2026, the office shall publish its first annual report concerning health care spending trends and underlying factors for the 2024 calendar year, with additional policy recommendations to control costs and improve quality performance and equity of the health care system. The office shall present the report at a public meeting of the board to inform the board, policy makers, and the broader public of implementation of the report's recommendations. The final report—taking into consideration public comment—shall be finalized at a later public meeting, submitted to the Governor and Legislature, and made available to the public on the office's website. Specifically, the annual report shall include[32]:

- Total health care expenditures and per capita total health care expenditures—utilizing the data from the HPD Program—disaggregated by service category, consumer out-of-pocket spending, and health care sector or geographic region;
- State's progress towards achieving the health care cost target and improving affordability;
- Drivers and factors of overall health care cost growth, using data from HPD Program and/or other data sources;
- Access, quality, and equity of care measures and data;
- Information on performance improvement plans required, administrative penalties imposed and assessed, and amounts returned to consumers/purchasers; and a
- Summary of best practices for improving affordability.

The Board

Within the office, a Health Care Affordability Board (the board) will be the body responsible for implementing key decisions of the office. For example, the board is charged with the key responsibility of establishing a statewide health care cost target. Additionally, the board has the authority to request the office collect additional data analysis and/or to establish advisory or technical committees to support its decision making.

The board will consist of 8 members, each with a demonstrated expertise in a health care-related field[33]:

- 4 appointed by Governor and confirmed by Senate,
- 1 appointed by Senate Committee on Rules,
- 1 appointed by Speaker of the Assembly,
- the Cal Secretary of HHS or their designee, and
- the Cal Public Employees' Retirement System (CalPERS) Chief Health Director or their deputy shall serve as a non-voting member.

The appointing authorities will take into consideration the state's diversity—in culture, sexual orientation, gender identity, and geography—so that the board reflects the communities of California.

Health Care Cost Targets

A significant responsibility of the board is to establish yearly statewide health care cost targets and specific targets for health care sectors.[34] The board must consider public comment before adopting a statewide or specific sector cost target. In addition, the board must approve the scope and range of administrative penalties for entities that are not in compliance with the targets. Notably, the statewide target for the 2025 calendar year will not be subject to enforcement. However, starting 2026 and thereafter, compliance with the established statewide target will be enforced.

Cost Target Enforcement

The Director of the HCAI will be charged with enforcement of cost targets.[35] Depending on the violation, the Director may take the following enforcement actions against health care entities in violation:

- Provide technical assistance to help the entity with compliance;
- Require or compel public testimony by the entity regarding its noncompliance with the target;
- Require submission and implementation of performance improvement plans, and monitor the entities' compliance; and
- Issue administrative penalties, starting with an amount commensurate with its initial noncompliance, and escalating additional amounts for repeated inability to meet targets.

However, the proposal establishes procedures the office must take prior to taking any enforcement action. First, the office must notify the health care entity that it has exceeded the health care cost target. The office must then give the entity not less than 45 days to respond and provide additional data, to which the office may modify its findings. And finally, the Director of the HCAI is required to consult with the Director of Manage Health Care or the Insurance Commissioner to ensure any technical assistance, performance improvement plans, or other measures are consistent with the laws applicable to regulating health care service plans and health insurers.[36]

Additionally, the Director of the HCAI may issue administrative penalties for non-performance improvement plan issues. For example, the Director may assess administrative penalties to a health care entity for willfully failing to report complete and accurate data, knowingly failing to provide information required, or knowingly falsifying required information.[37]

What to Expect Next: The Future of the OHCA?

In February, shortly after the release of the trailer bill language, the California Legislative Analyst's Office (LAO) issued a report summarizing and analyzing the Governor's various health care access and affordability proposals. Though the LAO acknowledged the Governor's proposal is a reasonable step in attempting to remedy the growing health care costs concerns, the LAO also indicated that it is an ambitious endeavor considering California's geographic size, population, and regional diversity, noting that California's health system is significantly larger and more complex than the other states that have established similar governing bodies.[38] The LAO also noted a couple of issues for the Legislature to resolve before adopting the proposal. First, the LAO suggests that the Legislature engage with the administration to seek reasoning behind the changes reflected in the trailer bill language from AB 1130.[39] For example, the original language in AB 1130 required a board of 11 members and gave the Director the responsibility of establishing cost targets, but the trailer bill language requires only 8 board members and giving them collective responsibility for establishing cost. targets. Second, the LAO suggests the Legislature adopt a more concrete legislative review process of the office's efforts and goals.[40] The LAO suggests "requiring regular check-ins, such as on a biannual basis, with the administration to gain information on how implementation is going."[41]

AB 1130, the legislative proposal to establish OHCA, is the primary legislation to track as establishing the OHCA will rely on the progression of AB 1130. Given the LAO 's recommendations, the Senate amended AB 1130 on February 14, 2022, and the current bill version predominately tracks the language of the Governor's proposal and adopts the trailer bill language. After passing the Assembly last year, AB 1130 is currently in the Senate Health Committee. Aside from AB 1130, which must pass the Senate, the 2022-23 Budget Bill, the

key funding to support the office, must also pass the legislature by June 15, 2022.

Potential Roadblocks & Limitations

While the Legislature and Administration seem to be working towards the same goal of getting AB 1130 enacted to establish the OHCA, outside stakeholders may still pose a roadblock in their plan, particularly the health industry and lobbyists. Some of the criticism focus on the data gathering and reporting requirements. Though the office will gather extensive data across the health care industry, transparency of that data remains an issue because not all the data will be public as proprietary information will be kept confidential.[42] The California Hospital Association noted another data concern—the OHCA may not be able to identify "'good spending,' like that on mental health care, from 'bad spending,' like duplicated medical records or overly complex paperwork."[43] The California Medical Association[44] also recently criticized the proposal, arguing that placing the same reporting burdens on solo practitioners and large hospitals is inequitable, which could cause more providers to merge[45] and potentially lead to greater costs for consumers.

Though establishing the OHCA is a good first step in working towards controlling costs, given the experience of other states such as Massachusetts and Oregon, it is critical that California adopt additional measures and move beyond just health care cost growth targets if policy makers wish to make real, long-term health care cost and affordability improvements. For example, even with the proposed reporting system gathering all health care payments in place, the data analytics—such as identifying and analyzing the location and cause of problematic spending and identifying the responsible parties—is a complicated endeavor. Moreover, health care systems are aware of ways to circumvent the system. Thus, even if the legislature enacts AB 1130 to establish the OHCA, policy makers must build upon this single mechanism as part of

a more comprehensive cost containment program.

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[1] For example, since 2008 health care premiums for job-based coverage have increased by 49%, while wages have remained stagnate. This means that a significant portion of workers' compensation is being used for health care benefits. Rising health care costs are not just seen through the rising premium costs, but average deductibles have increased significantly—since 2008, deductibles in California have increased by 84% for single enrollees and 77% for those with family coverage. Alex Matthews et al., Health care costs under job-based plans have grown rapidly, while wages remained flat, UC Berkley Labor Center (Dec. 3, 2019), https://laborcenter.berkeley.edu/health-care-costs-under-job-based-plans-have-grown-rapidly-while-wages-remained-flat/.

[2] Rebecca Catterson et al., The 2021 CHCF California Health Policy Survey, Cal. Health Care Foundation, at p. 3, 32 (Jan. 2021), https://www.chcf.org/wp-content/uploads/2021/01/CHCF2021CAHealthPolicySurvey.pdf.

[3] Richard M. Scheffler et al., The Sky's the Limit: Health Care Prices and Market Consolidation in California, Cal. Health Care Foundation (Oct. 3, 2019), https://www.chcf.org/publication/the-skys-the-limit/#summary.

[4] See The Source blog post "California Health Care Quality and Affordability Act (AB 1130) Passes Assembly, On Path to Creating Healthcare Cost Commission in California," for a thorough discussion on AB 1130, https://sourceonhealthcare.org/california-health-care-quality-and-affordability-act-ab-1130-passes-assembly-on-path-to-creating-healthcare-cost-commission-in-california/.

[5] Get the Facts About the Proposed Office of Health Care Affordability at OSHPD, Dept. of Health Care Access and Information (Feb. 24, 2021), https://hcai.ca.gov/get-the-facts-about-the-proposed-office-of-health-care-affordability-at-oshpd/.

[6] See supra note 4, for further discussion on other state healthcare cost commissions, https://sourceonhealthcare.org/california-health-care-quality-and-affordability-act-ab-1130-passes-assembly-on-path-to-creating-healthcare-cost-commission-in-california/.

[7] Gabriel Patek, The 2022-23 Budget: Health Care Access and Affordability, Legislative Analyst's Office, at p. 8 (Feb. 2022), https://lao.ca.gov/reports/2022/4560/Health-Care-Access-Affordability-022322.pdf.

[8] Health Care Cost Transparency Board, Washington Health Care Authority, https://www.hca.wa.gov/about-hca/health-care-cost-transparency-board (last visited Mar. 7, 2022).

[9] Id.

[10] See supra note 7, at p. 8.

[11] See supra note 7, at p. 8.

[12] Angela Hart & Samantha Young, Health Industry Wields Power in California's High-Stakes Battle to Lower Health Care Costs, Cal. Healthline (Oct. 12, 2021), https://californiahealthline.org/news/article/gavin-newsom-health-industry-executives-political-clout-battle-to-control-spending/.

[13] See supra note 7, at p. 9; Assemb. Floor Analysis of Assemb. Bill No. 1130, 2021-2022 Reg. Sess. at p. 2 (Ca. 2021) (as amended June 1, 2021),

https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=202120220AB1130.

[14] Health Care Payments Data (HPD), Dept. of Health Care Access and Information, https://hcai.ca.gov/data-and-reports/cost-transparency/healthcare-payments/ (last visited Mar. 7, 2022) (emphasis added).

[15] Id.

[16] See supra note 7, at p. 9.

[17] 2021-22 CA Budget Takes Major Steps to a More Universal & Equitable Health Care System, Health Access (Jul. 19, 2021),

https://health-access.org/2021/07/2021-22-ca-budget-takes-major-steps-to-a-more-universal-equitable-health-care-system/.

[18] See The Source blog post "A Record Final Budget for California Brings Funding for Medi-Cal Expansion and the Office of Health Care Affordability," https://sourceonhealthcare.org/a-record-final-budget-for-california-brings-medi-cal-expansion-and-funding-for-the-office-of-health-care-affordability/.

[19] See supra note 4, for detailed discussion on AB 1130, https://sourceonhealthcare.org/california-health-care-quality-and-affordability-act-ab-1130-passes-assembly-on-path-to-creating-healthcare-cost-commission-in-california/.

[20] Press Release, Jim Wood, Discussions Pause on Creating the Office of Health Care Affordability (Sept. 2, 2021), https://a02.asmdc.org/press-releases/20210902-discussions-pause-creating-office-health-care-affordability.

[21] Id.

[22] See California Health Care Quality and Affordability Act (Draft), https://esd.dof.ca.gov/trailer-

bill/public/trailerBill/pdf/578, for the entire trailer bill language.

[23] Id. at Article 2, section 127501(b), at p. 9.

[24] See supra note 22, at Article 3, at pp. 22-31, for more information.

[25] See supra note 22, at Article 4. Quality and Equity Performance, at pp. 31-32, for more information.

[26] See supra note 22, at Article 7. Health Care Workforce Stability, at pp. 35-36, for more information.

[27] See supra note 22, at Article 8. Health Care Market Trends, at pp. 36-39, for more information.

[28] See supra note 22, at Article 5. Alternative Payment Models, at pp. 32-33, for more information.

[29] See supra note 22, at Article 6. Primary Care and Behavioral Health Investments, at pp. 34-35, for more information.

[30] See supra note 22, at Article 2, 127501.3(a), at p. 11.

[31] See supra note 22, at Article 2, section 127501.4(a), at p. 12.

[32] See supra note 22, at Article 2 section 127501.6 (c), at pp. 16-17, for a comprehensive list of required information on the annual report.

[33] Each board member must have a demonstrated expertise in at least one of the following areas: health care economics; health care delivery; health care management or health care finance and administration, including payment methodologies; health plan administration and finance; health care technology; competition in health care markets; primary care; behavioral health, including mental health and substance use

disorder services; purchasing or self-funding group health care coverage for employees; enhancing value and affordability of health care coverage; or organized labor that represents health care workers. See supra note 22, at Article 2 section 127501.10, at pp. 19-20.

[34] The board shall establish statewide cost targets starting with the 2025 calendar year and every year after, and it shall establish specific cost targets for health care sectors by the 2028 calendar year. See supra note 22, at Article 3 section 127502(l), at p. 26.

[35] See supra note 22, at Article 2, 127502.5(a), at pp. 27-31, for more information.

[36] See supra note 22, at Article 2, 127502.5(b), at pp. 28.

[37] See supra note 22, at Article 2, 127502.5(h), at p. 30.

[38] See supra note 7, at p. 10.

[39] See supra note 7, at p. 10.

[40] See supra note 7, at pp. 10-11.

[41] See supra note 7, at p. 11.

[42] See, Adam Beam, California aims to limit health care costs with new office, Associated Press (Mar. 14, 2022), https://abcnews.go.com/Health/wireStory/california-aims-limit-health-care-costs-office-83438855.

[43] See id.

[44] See Victoria Colliver, Newsom’s plan to rein in health care costs has a primary foe, Politico Pro (Mar. 7, 2022), https://subscriber.politicopro.com/article/2022/03/newsoms-plan-to-rein-in-health-care-costs-has-a-primary-foe-00014370.

[45] See supra note 42.