STATE OF CALIFORNIA

DEPARTMENT OF MANAGED HEALTH CARE

PUBLIC MEETING ON HEALTH CARE PREMIUM RATES AND PRESCRIPTION DRUG COSTS

DEPARTMENT OF MANAGED HEALTH CARE

980 9TH STREET

5TH FLOOR CONFERENCE ROOM

SACRAMENTO, CALIFORNIA

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APPEARANCES

PANEL MEMBERS

Department of Managed Health Care
- Mary Watanabe, Director
- Amanda Levy, Deputy Director, Health Policy and Stakeholder Relations
- Pritika Dutt, Deputy Director, Office of Financial Review

California Department of Insurance
- Stesha Hodges, Chief, Health Equity and Access Office, Assistant Chief Counsel, Policy and Legislation Branch
- Joseph Williams, Senior Health Actuary

Office of Health Care Affordability
- Vishaal Pegany, Deputy Director

University of California, Berkeley Labor Center
- Miranda Dietz, Health Policy Specialist and Researcher

MEMBERS OF THE PUBLIC COMMENTING

Katie Van Deynze
Health Access California

Ian Lewis
Unite Here

Ivana Krajcinovic
Unite Here Health

Harvey McKeon
NorCal Carpenters Union

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PROCEEDINGS

1:08 p.m.

MS. LEVY: Welcome to everyone in the room and on Zoom today to the public meeting on health care premium rates and prescription drug costs. My name is Amanda Levy, and I am the Deputy Director for Health Policy and Stakeholder Relations for the Department of Managed Health Care. We are going to review our housekeeping notes very briefly for those in the room and online. Then we will hand it over to our Director Mary Watanabe for opening remarks.

So again, thank you all for being here. This meeting is being conducted in a hybrid format, with the opportunity for public participation in-person or virtually through video conference or teleconference.

Please note the following items for those joining us in-person today. The restrooms on this floor are locked. The bathroom badges are at the table at the back of the room. And please make sure if you use them to return them to the table. There are two all-gender, single-user bathrooms on the ground floor of the building near our mailroom. Security can provide that code to you if you choose to use those restrooms. There is a sanitation station in the back of the room where you will find masks and hand sanitizer.

Please remember, to everyone in the room, to silence your cell phones.

Public comment will be taken after the presentations. For those of you who wish to make a comment, please remember to state your name and the organization you are representing. Depending on the number of in-person participants versus online, we will alternate in-person and online public comment.

Seeing the number of people in the room we might choose to just go to those in the room first. For those making public comment virtually, it will be very helpful to use the Raise Hand feature and we will be calling on those people in the order in which we have, in the order in which they raised their hand.

For those of you joining online or via telephone, please note. For the public attending online, as a reminder, you can join the Zoom meeting on your phone should you experience a connection issue. For the attendees on the phone, if you would like to ask a question or make a comment please dial *9 and state your name and the organization you are representing for the record.

For attendees participating online with microphone capabilities, you may use the Raise Hand feature and you will be unmuted to ask your question or to leave a comment during public comment. To raise your hand, please click on the icon labeled Participants at the bottom of your screen, then click on the button labeled Raise Hand. Once you have asked your question or provided public comment, please click Lower Hand and we will know not to call on you once again.

As a reminder, this meeting is subject to the Bagley-Keene Open Meeting Act. Operating in compliance with the Bagley-Keene Act can sometimes feel inefficient and frustrating, but it is essential to preserving the public's right to governmental transparency and accountability. Due to the Bagley-Keene Open Meeting Act, the Zoom Chat has been disabled. If panelists or the public encounter any issues, please send an email directly to do.admin.support@dmhc.ca.gov.

One last note, we have Spanish language interpretation and American Sign Language Interpretation available today. Members of the public

who require ASL interpretation in-person will be able to see the ASL interpreter on the screen in the room. Those who require Spanish interpretation in-person should consult with our DO admin team sitting right here for further instructions. For members of the public participating online who require ASL interpretation, we will spotlight the ASL interpreters. For members of the public who require Spanish interpretation, please click on the icon labeled Interpretation at the bottom of your screen, then click Spanish, and tap the toggle to Mute Original Audio and click Done. Please note that interpretation features are not available to attendees dialing in over the phone. Again, if there are any questions, please email do.admin.support@dmhc.ca.gov.

With that, if we can go to the next slide to review the agenda. We are almost through Welcome and Introductions and then we will move to Opening Remarks. You will hear from the Department of Managed Health Care on the summary of our health care premium rates and prescription drugs costs. We will then move to the California Department of Insurance health insurance rates and premium drug costs presentation. We will next move to our Office of Health Care Affordability perspective. And then conclude our presentations with the UC Berkeley Labor Center on measuring consumer affordability. After the conclusion of the presentations, we will move to public comment and then end with closing remarks.

So, with that I would like to hand it over to our DMHC Director Mary Watanabe for opening remarks.

DIRECTOR WATANABE: Thank you, Amanda. Good afternoon, everybody. Seven years ago, I think it actually was seven years ago in 2017, we had our first public meeting in San Francisco to talk about premium rates in the

large group market. I had the honor of facilitating that meeting and we had hundreds if not over a thousand participants at that hearing. We took public comment up until I think the very last minute. And I think the piece that really has stuck with me is the overwhelming value of health care coverage. We heard stories of really lifesaving services that were provided to some of the individuals there. But there really was this overwhelming testimony as well about just the increasing cost of health care and what that meant for people trying to live or work in the San Francisco area. In particular, the challenges of affording housing and basic needs like food and taking care of their kids; what this meant for schools and other services in the city.

At a time when the average premium in, I think in the large group market was about $437 I think at that time, that seemed like a lot of money. And I think what you will hear today is the average premium is now over $600 per month.

While this is a really exciting time in California as we have expanded Medi-Cal coverage to all income-eligible Californians regardless of immigration status and we have one of the lowest rates of uninsured, it weighs very heavily on me that we saw double digit increases in the commercial market going into this year.

A recent poll by the California Health Care Foundation found that more than half of Californians say they skipped or postponed care due to the cost in the past year. Eight in 10 Californians have said that reducing what people pay for health care coverage is extremely and very important. Making this really a priority for my department but I think state government generally. Ensuring enrollees have access to just timely, high quality and affordable health care will

remain a priority for me as long as I am in this job. I am really excited that I think for the first time we are having the California Department of Insurance join us for this meeting. This really will be a comprehensive look at what is happening to premiums in the commercial market, for all of the lines of the commercial market that are regulated by either Department of Insurance or Department of Managed Health Care. So, this is really a comprehensive look at what is happening here.

I am also really excited to have the UC Berkeley Labor Center join us to talk about what this means for all of us as consumers of health care and what this means for, you know. It feels certainly, I think, like our wages haven't kept up with the pace of the growth in health care and even things like groceries. And then, of course, we have our Department of Health Care Access and Information and Office of Health Care Affordability to talk about what's happening in the state to try to rein in this growth in health care spending.

So, this is going to be a really exciting day. Heavy on the data and percentages and numbers. But I think we will tie it all together to really kind of give a comprehensive look of what's happening in the state and what this means for all of us.

Before I turn it back to Amanda, I do just want to take a moment to thank our Office of Financial Review, Pritika Dutt, who you will hear from in a minute, leads the team that does a tremendous amount of work every year to put our reports together. It is a lot of analysis that goes into this work along with her actuaries and consultants.

I also want to acknowledge Amanda and our Director’s Office admin team for the tremendous work that goes into preparing for these meetings, our dry runs. As you can see, we had to be nimble and flexible to adapt to the

always present technical challenges, so I just want to acknowledge the team that is putting this meeting on today. And with that, I will turn it back to Amanda.

MS. LEVY: Great. Thank you so much.

We are going to now begin with our DMHC's presentation, the summary of health care premium rates and prescription drug costs. I will be presenting along with Pritika Dutt, our Deputy Director for the Office of Financial Review.

We begin each of our presentations with the recitation of the DMHC Mission Statement, which is the California Department of Managed Health Care protects consumers' health care rights and ensures a stable health care delivery system. Next slide.

This infographic is from our Annual Report, and it really shows a comprehensive view of some of the accomplishments of the Department of Managed Health Care in the last year, and then certainly since 1999 and 2000 when we began.

Currently, the Department protects the health care rights of 29.7 million Californians and that represents 96% of state-regulated commercial and public health plan enrollment. We have 143 licensed health plans at the moment, and that is broken down between 97 full service and 46 specialized health plans. I think most important to some of the work we do and might be relevant for some folks who we are going to hear from today, our DMHC Help Center. We have assisted over 2.8 million consumers since its inception. Can move to the next slide, please.

So just to do a little level setting, we hope many of you are familiar with the work of the Department of Managed Health Care. But if you are not, we

just wanted to talk a little bit about who we are, who we regulate and how we do that. So, I will be brief.

But just wanted to, again, remark that the DMHC is the regulator of full service and specialized health plans in the state.

We have all the HMO and some PPO and EPO products.

We have some large group and most of the small group and individual products.

We oversee most Medi-Cal Managed Care plans.

And for our specialized plans those include dental, vision, behavioral health, chiropractic and prescription drug plans.

For Medicare Advantage we don't have full oversight but we do have financial solvency oversight of those Medicare Advantage plans.

And our key functions:

Number one, consumer protection; and again, I mention the DMHC Help Center. We won't go into more details about that but certainly happy to connect with any of you offline about the work of our Help Center. But it is really intended if any enrollee is having difficulty with their plans to help you access services and ensure if there's payment issues or anything like that. Ensure that you have a place and someone to help you out with those types of issues.

We license health plans and ensure compliance with state laws.

We oversee the plans by doing regular medical surveys of their health plan operations.

We oversee the financials of the plans with financial examinations to ensure financial stability.

We review proposed premium rate changes.

And we take enforcement action against plans that are in violation of the law.

And with that, I believe I am handing it over to my colleague Pritika Dutt for our summary of health care premium rates and prescription drug costs.

MS. DUTT: Good afternoon. I am Pritika Dutt, the Deputy Director for the Office of Financial Review. I will go over the findings from the 2023 large group, individual, and small group rate filings, and also highlight some of the findings from the Prescription Drug Transparency Report for Measurement Year 2022. The DMHC issued three reports that included more detailed information on the filings and these reports are all available as part of the meeting materials available on the DMHC's website. Next.

What does Large Group, Small Group and Individual market types mean?

So, large group coverage includes employer-sponsored coverage where an employer has more than 100 employees.

Small group coverage includes employer-sponsored coverage where the employer has 1 to 100 employees.

And the individual coverage is where health plans offer coverage to individual consumers. And most of the individual customers in California purchase coverage through Covered California's Health Benefit Exchange.

This chart shows the weighted average rate increase for health plans in the individual, small group and large group markets. As you can see from the chart, the average rates in all three markets increased in 2023. And based on the health plans' 2024 projected rate submission, we are expecting large increases in all three markets in 2024.

This chart shows the average monthly premium per enrollee in the individual, small group and large group market. So, this is showing the average monthly premium for enrollees in the three markets. The average premium in the individual and large group market are almost the same, while the small group market premium is slightly higher for 2023. A majority of the enrollees, almost 63% of all commercial enrollees, are covered under the large group market. From 2021 to 2023, the average premium in the individual market increased by 7%, for the small group market that increase was 14%, and for the large group market premiums increased by 10%; and that is looking from 2021 to 2023.

So next I will go over the large group aggregate premium rates.

So, pursuant to Senate Bill 546, and that's where it all started, that's a bill from 2015. Large group health plans are required to file aggregate rate information and specified information regarding health plan spending and year-over-year increases for covered prescription drugs annually.

The DMHC is required to conduct a public meeting regarding large group rate changes in even numbered years to permit a public discussion regarding changes in the rates, benefits and cost-sharing in the large group market.

Additionally, health plans are required to include information in their notice of premium rate change indicating whether the rate change is greater than the average rate increase for CalPERS and Covered California, or the average rate increase in the large group market.

The DMHC received the aggregate rate filings from 23 health plans for measurement year 2023, including eight statewide plans. So, the statewide plans are offering products in many counties, so spread out through the state.

There are 10 regional plans, and the 10 regional plans were offering products in specific counties, and then we had 5 in-home support services plans, IHSS plans.

Approximately 7.8 million enrollees were covered in the large group markets, in the large group plans licensed by the DMHC. The large group rate increased by 6.5% on average, and the average premium per enrollee per month was $589 in 2023.

As I mentioned earlier, health plans are also required to include information on their notices to employers that compares the rate change to those in Covered California and CalPERS. Covered California and CalPERS negotiate rates with plans similar to large employers, so it gives them some comparison for -- it provides some comparison to the large group employers. And you can see the average rate increases in this table from 2019 to 2024.

This chart shows the premium per member per month by year from 2016 to 2023. The statewide premiums have consistently been lower each year than compared to the regional average premiums. However, the gap between average premiums for statewide and regional plans got smaller starting in 2022. For statewide plans, the average premium increased by $152 or 35% from 2016 to 2023. For regional plans, the average premium increased by $128 or 27% from 2016 to 2023. The average premium per member per month continues to rise every year, which is consistent with the renewal increases, as you will see on the next slide.

This chart shows the average rate increases for 2016 to 2023 for statewide and regional plans in the large group market. Over the most recent four year period it is clear the average increase for regional plans have been

much lower than their counterpart statewide plans. However, as seen on the previous slide, the average premium was lower for the statewide plans compared to the regional plans.

This table shows the average rate increase in number of enrollees and average premium per member per month for all large group plans, and then Kaiser, and all plans excluding Kaiser. Kaiser makes up about 66% of the large group market so they have been separated here to show the average rate increase for all plans excluding Kaiser. Kaiser reported an average rate increase of 5.9% with an average monthly premium of $572. Excluding Kaiser, the remaining large group plans covered 2.6 million members and reported an average increase of 7.6% and average premium of $622. The average rate increase was 6.5% for all plans in the large group market and the average premium was $589.

Assembly Bill 731 expanded the rate review practice the state already had in place. Upon receiving a notice of a rate change, a large group contract holder that has coverage that is experience rated in whole or blended can request the DMHC to review its rate change if the contract holder makes a request within 60 days of receipt of the notice.

A large group contract holder may only request a review of their rate change from the health plan licensed by the DMHC.

To apply for review of the rate change for a particular group, a particular group has to at least meet one of the following:

The contract holder has to have more than 2,000 enrollees. That includes the employees and their dependents; or the rate change is from a health plan that failed to provide claims information requested by the large group

employer.

Now I will summarize the 2023 individual market rates.

So, in 2020, California enacted Assembly Bill 2118, for the purpose of increasing transparency of rates in the individual and small group markets. Health plans that offer commercial products in the individual and small group markets are required to report specified information, including rates, premiums, cost-sharing, benefits, enrollment and trend factors to the DMHC by October 1 each year. The DMHC is required to annually present the reported information at various meetings as specified and post the reports on the DMHC website no later than December 15 of each year.

The next slide will summarize the aggregate rate information and weighted average increase on health plan premiums for individual market coverage for measurement year 2023 and compare information between On-Exchange, Off-Exchange and grandfathered products.

For measurement year 2023, 13 individual plans submitted data to the DMHC.

The 13 health plans covered approximately 2.35 million enrollees.

The weighted average rate increase for the individual market was 5.6% on average.

And the average premium per enrollee per month was $590.

For measurement year 2023 the DMHC received individual market data, like I said, from 13 plans that included 5 statewide plans and 8 original plans. The 13 individual health plans covered 2.4 million enrollees. Overall, the weighted average rate increased by 5.6%. The average premium per member per month across all plans was $590, as I mentioned earlier.

Twelve of the health plans offered individual products On-Exchange and covered 1.84 million enrollees, with an average premium of $590 per member per month.

Twelve health plans offered individual products Off-Exchange also and covered 474,000 enrollees, with an average premium of $583 per member per month.

Only two health plans, which was Anthem and Kaiser, offered grandfathered plans and these are pre-ACA products that are offered by Kaiser and Anthem. These two plans covered 41,000 enrollees with an average premium of $697.

In this next section, I will summarize the aggregate rate information and weighted average rate changes on health plan premiums for small group coverage in measurement year 2023.

The DMHC received small group aggregate rate filings from 13 health plans for measurement year 2023, including seven statewide plans and six regional plans.

In 2023, approximately 2.24 million enrollees had small group coverage.

The weighted average increase was 7.1%.

With an average monthly premium of $605.

Overall, the weighted average rate increased by 7.1% and average PMPM was $605, as I previously mentioned.

And then small group Off-Exchange plans covered 2 million enrollees, accounting for almost 90% of total enrollment in the small group market.

The weighted average rate increase for small group Off-Exchange products was 7.1% and had an average premium of $609.

The small group grandfathered plans covered 151,000 enrollees, with an average increase of 7.4% and average premium of $564.

And in 2023, On-Exchange plans had an average increase of 7.3% for 77,000 lives, with average premium of $592 per member per month.

Now, I will briefly go over the prescription drug cost transparency report for measurement year 2022.

In 2017, California enacted Senate Bill 17 with the purpose of increasing transparency of prescription drug cost. Health plans are required to file information with the DMHC on specified data related to prescription drugs annually by October 1. Health plans must report to the DMHC information on their top 25 -- 25 most frequently prescribed drugs, 25 most costly drugs by total annual spending, 25 drugs with the highest year-over-year increase in total annual spending. The DMHC issues an annual report that summarizes how prescription drug costs impact health plan premiums. Plan reporting is limited to prescription drug costs associated with the pharmacy benefit. Health plans do not include prescription drug costs for in-patients or costs borne by delegated medical groups. Prescription drug costs for self-funded arrangements, Medi-Cal Managed Care, Medicare Advantage, and plans not regulated by DMHC are not reported in the report issued by the DMHC. So, 25 commercial health plans reported to the DMHC and they covered 12.6 million enrollees.

Health plans paid more than 12 -- so, I will go over the key findings here quickly.

So, health plans paid more than $12.1 billion for prescription drugs

in 2022, an increase of almost $1.3 billion from 2021 and an increase of $3.4 billion since we first started collecting information in 2017.

Prescription drug costs accounted for 14.2% of total health plan premiums in 2022, an increase of 13.3% since 2021.

Health plans' prescription drug costs increased by 12.3% in 2022, whereas medical expenses increased by 7.9%.

Overall, total health plan premiums increased by 4.4% from 2021 to 2022.

Manufacturer drug rebates totaled approximately $2.1 billion, which was up $1.7 billion since 2021. And an increase -- excuse me, I will repeat the sentence here. Manufactured rebates totaled approximately $2.1 billion in 2022. It was $1.7 billion in 2021 and was $1.4 billion in 2020. This represents about 17.1% of the $12.1 billion spent on prescription drugs in 2022.

Specialty drugs accounted for 1.6% of prescription drugs dispensed but accounted for 64% of total annual spending on prescription drugs.

Generic drugs accounted for 88.9% of all prescribed drugs, but only made up 14.4% of total annual spending on prescription drugs.

For 2022 the primary drugs that contributed to the increase in prescription drugs were in the specialty and brand name categories. Many of these drugs such as Jardiance -- and I think I am butchering the pronunciations here. So, Jardiance, Ozempic, Victoza, FARXIGA, Wegovy. So, many of these drugs are used for management of diabetes or weight loss.

So, on this slide we are sharing the links to the detailed reports. So, if you want to see the detailed reports that were issued by the DMHC you can click on any of these links and you can go see the large group report, and

the Individual and small group, and then also the prescription drug cost report for measurement year 2022. And then that wraps up my presentation. I will turn it back to Amanda.

MS. LEVY: Thank you, Pritika, so much for your presentation.

We are going to next move on to the California Department of Insurance Health Insurance Rates and Prescription Drug Costs with Stesha Hodges and Joseph Williams.

MS. HODGES: Hi. Next slide, please.

Hi. I am Stesha Hodges. I am an Assistant Chief Counsel and Chief of the Health Equity and Access Office at the California Department of Insurance. I want to welcome you all to the California Department of Insurance portion of this public meeting which pertains to health insurance rates and prescription drug costs. First, I want to extend my gratitude to Director Watanabe, Deputy Director Levy and Deputy Director Dutt for inviting us to present and for hosting this public meeting. I also want to thank DMHC staff who put this public meeting together. Thank you all. Next slide.

Before we go into the main presentation, I want to give you a brief overview about the California Department of Insurance or CDI. The California Department of Insurance was created in 1868 as part of a national system of state-based insurance regulation.

CDI is led by California Insurance Commissioner Ricardo Lara. Commissioner Lara is the eighth Commissioner since voters created this elected position in 1988.

California is the largest insurance market in the United States and the fourth largest insurance market in the world, with annual direct premiums of

over $340 billion.

And CDI is tasked with regulating more than 1,400 insurance companies. And this is across all types of insurance such as life insurance, property and casualty insurance, long-term care, and health insurance, which we are talking about here today.

CDI regulates health insurance products offered by disability or health insurers. This includes review and prior approval of health insurance policies and prescription drug formularies, as well as review of networks and rates to ensure compliance with state law. Next slide.

Go back one slide please.

CDI has a consumer protection mission and focus, which includes overseeing insurer solvency, licensing agents and brokers, conducting market conduct reviews, investigating and prosecuting insurance fraud, as well as assisting consumers and resolving consumer complaints.

And across all types of insurance regulated by CDI, in 2023 CDI's Consumer Services Division received more than 201,000 consumer complaints, investigated and resolved more than 58,000 consumer complaints, and as a result recovered more than $129 million for consumers. And this work included providing in-person assistance after disasters at 52 Disaster Recovery Centers and Local Assistance Centers, where CDI's Consumer Services Division assisted more than 2300 individuals face to face.

So, if you need assistance with any of your insurance needs, go to our website. That's www.insurance.ca.gov and press on the File a Complaint tab; or else you can call the CDI's consumers Services Division at 1-800-927-HELP. Next slide, please.

Now we will transition to the part of the presentation you are all here for, the health insurance rate presentation. I would like to introduce one of CDI's senior health actuaries, Joe Williams, who will present information regarding health insurance rates starting with large groups. Joe, take it away.

MR. WILLIAMS: Thank you, Stesha. Let's get into the large group data. Next slide, please.

The large group aggregate rate data is available on the Department's website at www.insurance.ca.gov. Just type large group rate into the search box in the upper right of the home screen and that will take you to a link to large group rate submissions as well as the prescription drug cost data submitted by each insurer this year. Next slide.

In 2023, CDI received large group aggregate rate data from seven health insurers. That's total covered lives of 655,000. These are their market shares. Next slide, please.

Carriers submitted data on the rating methodology for their different groups. Here we see that 44% of the large groups are experience rated; this means that they are rated on their own experience. Whereas only 3% are community rated; this means they are rated on a manual rate due to a lack of credibility. And then the remaining 53% have a blended methodology where it blends the group's own experience with the manual rate. Next slide, please.

The Department now has eight years of SB 546 data from 2016 through 2023 submission years. The data indicates that the product mix has been relatively stable, though we see some shifts between PPO products and HDHPs in recent years. Next slide.

This slide shows the distribution of market shares by actuarial

value. You can see that 21% of members are in plans that cover over 90% of the claim costs. And 71%, cumulatively 71% are in plans that cover over 80% of claim costs. In a slide later on we will see, we will see this distribution for the small group market. But in general, plans offered in the large group market tend to provide richer benefits compared to those in the individual and small group markets. Next slide, please.

Here we see the average premium average and average claims PMPM increasing over the years. We see average premium PMPM increased 1.5% in 2022, where claims increased .1% in 2022. Next slide.

Health insurers are required to include information in their notice of premium rate change indicating whether the rate change is greater than the average increase in Covered California and CalPERS. In 2024, rate increases are 10.9% for CalPERS and 9.6% for Covered California. Next slide.

This slide shows the weighted average annual increase for 2023 over 2022. The blue bars are unadjusted, where the red bars show the percent increase adjusted for aggregate changes in benefits and demographics. We see quite a bit of range from company to company ranging from 2.3% for KPIC, up to 14.7% for Blue Shield. Next slide, please.

This slide shows the rate changes by product type. For 2023 reporting year, rate changes for PPO, EPO and HDHP plans were all similar. Whereas for 2022, EPO plans had higher increases compared to the other two product types. Next slide.

This slide shows the overall medical trend. The top shows the historical medical trend comparing 2023 over 2022; and the bottom shows projected medical trends for 2024. We can see here, for large group carriers

they are projecting higher trends for 2024. Next slide.

This slide shows the projected medical trends separated by service category. We have hospital inpatient, hospital outpatient including emergency care, professional services, and prescription drug. We can see there is significant variation and trend projections between companies in each of the four service categories. Next slide, please.

On this slide, on the top we have the average post-tax margin as a percent of premium. This is averaged over all carriers who submitted for each year from 2018 through 2022. We can see overall it has been decreasing, other than a slight .8% increase in 2022. The bottom portion of the slide shows the average for each of the carriers over those five years. Next slide, please.

This slide shows the average admin expenses, average administrative expenses as a percent of premium. The top figure is the average across all the carriers for each of the five years. We can see it has been steadily increasing from 5.8% in 2018 up to 7.2% in 2022. The bottom figure shows the average over the five years for each of the carriers. Next slide, please.

Now I will move on to the AB 2118 submissions and we are going to talk about data from the individual market. Next slide, please.

The individual and small group aggregate rate data is available on the department website at www.insurance.ca.gov. Just type Individual and Small Group Aggregate Rate into the search box in the upper right of the home screen and that will take you to a link to the Individual and Small Group rate submissions. Next slide.

In 2023, CDI received individual aggregate rate data from 4 health insurers. As you can see, over 99% belonged to 2 health insurers so we will

focus our slides on those two. All of these are PPO plans, and they are all grandfathered plans as well. Next slide, please.

Here we look at the overall medical trend. The historical showing 2023 over 2022 and the projected on the bottom showing the projected trend of 2024 for over 2023. In this case, both carriers are projecting smaller trends than in the past. Next slide, please.

Here we have a breakout of the projected trend by service category. Again, hospital inpatient, hospital outpatient including emergency care, professional services, and prescription drug. And again, it varies for each carrier in all four categories. Next slide, please.

Now we will talk about the AB 2118 submissions of the small group market. Next slide, please.

Okay, I have explained this one multiple times now, but you can type it in the search bar. You will find the submissions on our website at www.insurance.ca.gov. Next slide, please.

In 2023 CDI received small group aggregate rate data from 6 health insurers. Here are the market shares. Most of them are in PPO plans, around 7% in EPO plans. Next slide, please.

Here we have the market share by actuarial value. Around 50% are in plans Gold or higher, Gold or Platinum. So, compared to the slide we saw earlier in the large group, that was around 70% that had 80% AV or higher. Also, here we see in the Bronze plan which is about 60% actuarial value, we have about 30% of membership in the leaner plan. Next slide, please.

Here we have overall medical trend for the small group market. The top figure is the historical 2023 over 2022; whereas the bottom is the

projected 2024 over 2023. Next slide.

And again, the projected trend for the small group broken out into service categories, hospital inpatient, hospital outpatient including emergency care, professional services, and prescription drug. And again, we see from carrier to carrier a lot of variation in each of the four service categories. Next slide, please.

Now I am going to turn the time back over to Stesha who is going to talk about prescription drugs.

MS. HODGES: Thank you, Joe. So, insurers are required pursuant to Senate Bill 17, which was enacted in 2017 to report information regarding outpatient brand name, generic and specialty drugs in each of three categories. These are the ones that Pritika mentioned before but I am going to go over them again. The 25 most frequently prescribed drugs, the 25 most costly drugs by total annual plan spending including cost-sharing, and the 25 drugs with the highest year-over-year increase. This is a summary of CDI's findings based upon an analysis of prescription drug cost information provided by health insurers. Next slide.

Seven health insurers submitted the prescription drug data required by SB 17. Changes in drug spending varied greatly by insurer. As you can see, two insurers had rather large changes in drug spending. Anthem and Nippon both attributed increased utilization of specialty drugs such as immunological agents that treat inflammatory conditions for their increases in spendings. However, Nippon did note that some of its rebates have been underestimated due to the timing of submissions. Next slide, please.

This slide shows the total percentage of prescription drug cost --

total cost of prescription drugs accounted for by premium. Note the cost for medical providers, facilities and other components of medical care account for the remaining percentages. And this confirms that although the cost for prescription drugs varies greatly by insurer, that outpatient prescription drugs are significant, with insurers spending an average of over 14% of premiums on prescription drugs once rebates are subtracted. Next slide, please.

This slide shows cost and utilization for 2022. So, the circle on the left shows that 82% of prescriptions are for generics, but only 3% of prescriptions are for specialty drugs. And this is similar to what we saw in 2020 and 2018, plus or minus a few percentage points.

In contrast, the circle on the right shows that as a percentage of costs, specialty drugs account for 65% of prescription drug costs. And this is up from 55% in 2018, and 64% in 2020. While generic drugs account for only 13% of costs, which is down from 20% in 2018, and 16% in 2020. And finally, brand name drugs account for 22% of costs, which is down from 25% in 2018, but it is up from 20% in 2020.

What these two charts demonstrate is that generic drugs are very cost efficient. Next slide, please.

This slide shows the top three most prescribed drugs in each category, as well as the ranking and annual spending by each respective category. For instance, although Ozempic was the number one prescribed specialty drug, it was number 10 in annual spending. And for brand name drugs, the top prescriptions were all vaccines. But the Pfizer COVID-19 vaccine is the only vaccine in the top 25 ranking for annual spending due to higher utilization than the other two vaccines. And this information is displayed to show a preview

of the detailed information available to you in the Department's report. Next slide, please. Next slide, please. Thanks.

To access CDI's report, go on the Department's website. That's once again www.insurance.ca.gov and search for Special Health Topics and Resources and you will find a link to our report. Next slide, please.

This concludes the CDI portion of this meeting. Thank you all for your interest in our presentation.

MS. LEVY: Thank you so much, Stesha, and thank you, Joseph. Appreciate the perspective from California Department of Insurance.

We are going to move to the next slide. We are happy to have Vishaal Pegany, the Deputy Director of the Office of Health Care Affordability within HCAI, the department of Health Care Access and Information. He is going to talk about the Office of Health Care Affordability, give you an overview, and talk about the work that they are doing. Thank you.

MR. PEGANY: Good afternoon. So, I will give an overview of HCAI and the Office of Health Care Affordability. Next slide. Just one more.

OHCA is housed within the Department of Health Care Access and Information, which was formerly known as the Office of Statewide Health Planning and Development or OSHPD. The department was renamed a few years ago to better reflect its responsibilities and portfolio. The mission statement is listed here, which is to expand equitable access to quality, affordable health care for all Californians through resilient facilities, actionable information, and the health workforce each community needs. Next slide.

As you can see here, HCAI has several program areas, including a historic responsibility of ensuring compliance with seismic safety requirements for

health facilities.

HCAI also manages several data assets, particularly the newly established Health Care Payments Data Program, which is California's All Payer Claims Database or APCD. It is a valuable research database comprised of health care administrative data, including claims and encounters, that were generated by transactions among payers and providers.

HCAI also has several workforce programs that are intended to improve access by providing scholarship loan repayments and grants to students, graduates and institutions.

And then lastly, this new program area of affordability is the newest addition to HCAI's portfolio.

In this presentation I will cover key provisions of our statute and provide some detail on our near-term priorities. Next slide.

So, I want to provide some context on what led to the administration and the legislature in enacting an Office of Health Care Affordability. Next slide.

This graph displays the growth in health care spending as a share of median income. Shown in red is the value for the overall United States, with California figures shown in blue. In the 1990s, health care spending was relatively flat in the in the state and nation but began a steady climb around 2000. We see California households spending 7.9% of income on health care in 1991, and this growing to 13.3% in 2020. Households spend an increasingly larger share of household income on health care, crowding out other necessities and priorities for families. Next slide.

Looking more closely at California, we see average health care

spending growing from about 2,700 in 1991 to 10,300 per capita in 2020. This translates to a 4.8% annual growth rate between a 30-year period between 1991 to 2020. I want to note that between 2010 and 2018, wages and inflation grew 20%; during the same period per capita spending on health care grew by 40% or double the rate. Next slide.

It is not just premiums that have increased dramatically. Part of the costs shifting to consumers is through plans with higher and higher deductibles. Here we see the growth of family deductibles, which have quadrupled in the past two decades. Employers with less than 50 employees are indicated by the yellow line. They saw a 10% annual growth rate. While employers with 50 employees or more saw a 9% annual growth rate, as shown in the gray line. Next slide.

Shifting gears a little bit to, you know, note the human impact and the human toll of higher health care costs. As the Director mentioned earlier, a 2023 survey commissioned by the California Health Care Foundation found more than half of Californians and more than two-thirds of those with lower incomes, which is defined as under 200% of the federal poverty level, report skipping or delaying at least one kind of health care service due to cost, in the past 12 months. Among those who report skipping or delaying care due to cost, about half report that their conditions worsened as a result. Not shown in these figures is that the high cost of health care disproportionately affects Black and Latino Californians, of which respectively 36% and 40% report that they had problems or were unable to pay medical bills. In contrast, only 20% of white Californians report these concerns. Next slide. And one more, please.

So, these are the three components of OHCA. OHCA was

established to address consumer affordability by, one, slowing spending growth; two, promoting high value system performance; and three, assessing market consolidation. I will mostly focus on the yellow circle of slowing spending growth for today, but just want to briefly note that promoting high value system performance, we also include other balancing measures focused on measuring quality and equity, measuring the adoption of alternative payment models or value-based payments, measuring the proportion of health care spending on primary care and behavioral health. Those are all the balancing measures non-cost related in terms of non-spending target related that are intended to promote a high value system. And then lastly, we have a distinct program focused on addressing market consolidation through prospective reviews of proposed mergers, acquisitions and corporate affiliations. So, moving on to the next slide.

So, the office will collect, analyze and report data on THCE or total health care expenditures.

The office will develop a spending target methodology that considers economic factors and population-based measures and then set a numerical value for a spending target. Initially, there will be a statewide target for calendar year 2025. This past January the office announced a proposed target, and I will be sharing that in a later slide. The Board will have until June to approve the target. The first year will be a reporting year only and the first enforceable spending target will be for calendar year 2026. Eventually, the office will set sector specific targets. These can include geographic regions, certain types of entities or fully integrated delivery systems.

And then lastly, there will be a progressive enforcement approach beginning with technical assistance, public testimony at a public meeting of the

Board, performance improvement plans, and as a last resort, the office can assess financial penalties. Next slide.

So, what is a spending target? A spending target establishes a maximum limit on an acceptable rate of spending growth for health care entities. The goal is to slow the growth of health care spending and make health care more affordable.

The Board, with input from the Advisory Committee as well as public comment, will soon establish a spending target for California. Next slide.

So, here is the timeline we have shared at our public meetings. Our public comment period just closed this past Monday, so we are in this phase of where the orange circle is. The Board may adopt a spending target sometime between now and before June 1. Next slide.

So, this is the staff recommendation to the Board for the adoption of a 3% statewide per capita health care spending target for a 5-year period between 2025 to 2029. This recommendation was based on the average annual rate of change in historical median household income over the 20-year period from 2002 to 2022. There are several reasons for why we recommended tying the target to historical median household income growth. First, basing the target on this measure adheres to the enabling statute’s requirement to promote the goal of improved consumer affordability. This is also in alignment with the Board's preference for using a consumer-centric economic indicator rather than an overall economic measure such as GDP. Most importantly, tying to historical median household income growth signals that health care spending should not grow faster than the income of California's families. Next slide, please.

So, it is really good to be here today to highlight a portion of the

enabling statute, which was Senate Bill 184, which added language shown here to the Health and Safety Code for DMHC and similar language to the Insurance Code for CDI. The purpose of the language was to convey that those with health coverage should benefit from the intended impact of a spending target to slow the growth in health care costs. We are in the early stages of implementation. The Board has yet to act on a spending target. But OHCA will work with DMHC as well as with CDI on creating a feedback loop so that the spending target and the data that we publicly report is considered during each of the Departments' respective work on premium rate review. Next slide.

So, this is the parallel language that is added to the Insurance Code. Next slide, please.

That wraps up my portion and happy to pass it back to Amanda.

MS. LEVY: Great, thank you so much, Vishaal. It is really exciting to have, since we broadened the meeting out, to have other departments with us to try to connect the dots as we work together moving forward.

With that, we are running just a little bit ahead of schedule, which is great. We are going to move to our UC Berkeley Labor Center. We have Miranda Dietz with us who will be presenting on measuring consumer affordability.

MS. DIETZ: Great. Good afternoon and thank you so much for inviting me to the meeting today. My name is Miranda Dietz, and I am a Health Policy Specialist and researcher at the UC Berkeley Labor Center. The Labor Center was founded 60 years ago to work on the most pressing problems and economic challenges affecting working families in California and across the country. And we provide timely, policy-relevant research on labor and

employment issues for policymakers and for stakeholders, as well as conducting trainings for a new and diverse generation of worker-leaders and students.

Our health care research program examines access to health coverage and health care affordability for workers and their families.

So, on the next slide you can see a picture of the report that we put out in January on measuring consumer affordability. We wrote this report for two reasons. Number one was to look at the historical trends in job-based coverage and affordability in the last 20 years, which helps further demonstrate the need for improved consumer affordability; and it also underscores the need to monitor progress on that going forward. The second reason was to make some specific recommendations about the measures that OHCA could use to track consumer affordability as part of its annual report. So what I want to do this afternoon is sort of walk through our findings about worsening affordability and share some of the ways that the administrative data that the state already has, and that you have seen presented here today, combined with the data that OHCA will collect, how that can help OHCA track and really start to capture the big picture of what is happening with consumer affordability going forward. So that's the plan.

Next slide is, you know, the headline of our historical analysis is that consumer affordability for health care has deteriorated in the last 20 years. We are going to focus on commercial insurance, especially job-based coverage, which is still where most Californians, especially most folks under the age of 65, are getting their insurance.

So, on the next slide when we look over the last 20 years at the average annual growth rates, so that's if you averaged out how much stuff has grown every single year in the last 20 years, this is where we see that

Californians' median wages and median household income has grown at an average of 3% per year. Those are those green bars at the bottom. And that's also where that staff recommendation for OHCA came from, right, is that 3% average annual growth rate.

But when we look at health care costs over this same time period, they have gone up much faster, right.

The size of deductibles, those orange bars, have increased almost 8% per year for family deductibles, and almost 9% per year for single deductibles.

Premiums have increased faster as well. Total premiums have increased about 5% per year, those are the dark blue bars. In 2022, single premiums were about $7,000 and family premiums about $21,000 annually.

The worker share of premium, those are those light blue bars, those have increased more than 6% per year. So, health care growing much faster than wages and income.

On the next slide we can focus on deductibles, because it is not just that deductibles are growing in size, it is also the case that more and more Californians face deductibles. So, the Medical Expenditure Panel Survey looks at private sector establishments. This matters because public sector workers are actually less likely to have deductibles. But we can see the pretty dramatic increase in the share of private sector workers enrolled in coverage with a deductible from just one in three in 2002 to three out of four today, or in 2022. So, this increase in consumers' exposure to health care prices, it hasn't had the hoped-for effect of limiting the use of low value or unnecessary care. Instead, what it does is it leads to reductions in all types of care, including needed care

and high-value care. So, this high cost of care is really limiting access.

And we think deductibles are really problematic also for lower and moderate-income families. The average family deductible was $3,600 in California in 2022 but for some folks it is even more. And a survey of families in the US found that 4 in 10 had less than $4,000 in liquid assets, right, and the median deductible is $3,600. Deductibles that are this high and this prevalent are a real barrier for California families.

On the next slide, we can see that kind of the result of all this is that health care is taking up a larger share of household budgets. In 2002, you probably didn't have a deductible, and your employee share of a family premium was about $2,000. If you had the median household income in that year, that equates to 4.2% of your income. If we fast forward to 2022, chances are you do have a deductible and you are paying more for premiums too. So, when we add average premium plus the potential deductible spending, it is more than $10,000, which is more than 12% of median household income. So, the cost of buying coverage and getting care are increasingly unaffordable. We have been paying more and getting less. And this has negative consequences, right, for our health, for our financial wellbeing and for equity.

On the next slide we can dive into one of the important negative consequences for Californians' financial health and how often the high cost of care results in medical debt. In 2023, more than one in three -- the headline here is wrong, sorry, it's worse than that, it is 38%, that dark blue bar at the bottom. More than one in three California adults report having some type of medical debt, whether that's money that's owed to a family member or put on a credit card that they are paying off or some combination of those things. And this debt can have

its own health and financial consequences for folks. Bad credit scores make it hard to rent an apartment, get a job, get a car, and those who have medical debt are much more likely to skip or delay getting the care that they need.

Even if you don't go into debt, on the next slide we can see that you might still find it hard to afford those medical bills. This is from the California Health Care Foundation Health Policy Survey, and it lets us look at who reports that they or a family member had trouble paying medical bills in the last year. Both overall, that gray line in the middle, and by race and ethnicity. When we look at those who have trouble paying for medical bills, and this is also true of medical debt, the prevalence is higher among both lower income Californians, and as you can see here, Black and Latino Californians.

Finally, on the next slide, we can see that unaffordable care doesn't just affect Californians financially, it also affects our health. High costs are a barrier to care. As we heard from a couple other presenters, right, half of the population in California say that they or a family member have skipped or delayed care in the past 12 months due to cost. This breaks down both by race and ethnicity and by some of the particular things that people mentioned skipping or delaying care on. And that figure of half of people skipping or delaying care might be they skipped or delayed just one of these things or they might have done multiple. So, across all the possible services, all these different categories for which someone might skip or delay care, you can see that Black and Latino Californians are more likely to have skipped or delayed care, whether that's mental health care, physical health care, or getting a recommended test or a prescribed medicine. And these delays in care have consequences for people's health and they exacerbate inequity by race and ethnicity. Okay, so that's the

history of what has been happening with consumer affordability in California. Next slide.

Now we want to look at the future, right. We want to change this story. OHCA is undertaking this really important mission to slow total health care spending. They are collecting total health care expenditure data to assess whether different entities are meeting the target. But their charge, and our hope is, that this translates into improved affordability for consumers.

So how are we going to know if that is happening? The first thing we need to do, right, is measure it. So on the next slide, OHCA is going to produce annual reports and we think that a set of consumer affordability measures have a place in that report. Unfortunately, there's not just one number we can look at. For example, if you had flat premiums, that could be offset by reductions in the generosity of a plan. Or if you had lower actual out-of-pocket spending, that could just be because care is so unaffordable that folks aren't getting it.

So, we think of the different measures falling into sort of three categories, changes in the cost of coverage, right. How are premiums changing. Changes in the cost of care. So how are deductibles, coinsurance, copays, out-of-pocket costs, how are those changing. And then this third category that's about changes in the consequences of unaffordable coverage and care. So that's like the survey results that we just talked about, right. The prevalence of medical debt, trouble paying for medical bills, and skipped or delayed care due to cost.

To capture these measures, we think we are going to need a combination of both administrative data and survey data. administrative data is

really great here. It is not a sample, right, it is the whole population, so we can use it for kind of year-over-year comparisons. And we are lucky in California that we have some good sources, namely the Department of Managed Health Care and the Department of Insurance data from fully insured plans that we have seen today, as well as some data that OHCA is going to be collecting on total health care expenditures.

So, let's look for a minute on the next slide at some of the administrative data that California has that we can use to track premiums and out-of-pocket costs. So, the top here is just the DMHC data on the average premium growth by market. The large group market number is even adjusted to reflect changes in benefit design, that is why it is the 6.8 instead of the 6.5 you saw earlier in the slides. This doesn't cover everyone with commercial health insurance in California but it is most, and we can combine this with the 750,000 or so who are in Department of Insurance regulated plans for an even fuller picture of what's happening in California.

And then OHCA is also going to be collecting data on aggregate out-of-pocket spending. And this is going to be extremely useful for answering this pretty basic question about consumer affordability. How much are people with commercial market coverage spending out-of-pocket on average and how is that changing? We don't currently have a good answer for this fairly basic question right now, but we will.

So on the next slide is another great bit of administrative data that we have on actuarial value, right. We saw some of this from the Department of Insurance earlier and these slides focus on the DMHC data. I think of actuarial value as a measure of like the generosity of the plan, right. What share of

medical expense expenses is the plan going to cover on average? Those of us with large group, fully insured plans, tend to have 90 to 100% of expenses covered. That's the range that Covered California calls a Platinum plan. But in recent years, the share of folks with this generous coverage has been declining. I think it used to be around 80%, and now in 2023 it is 72% of the large group plans regulated by DMHC have coverage in that range. Small group coverage is more distributed. And then in the individual market coverage is even less generous on average, right, with more than a quarter of enrollees in Bronze plans that are only covering 60 to 69% of expenses. My main point here is that actuarial value, AV, is really a crucial way of summarizing the generosity of plans, given all the different ways that a plan can have cost-sharing, right. Deductibles or coinsurance or copays or all of those together, right, is a useful way of just sort of summarizing what people are getting for their premium.

So, as I said, we are really fortunate that we have a lot of great data to start with, both the administrative data we focused on today and the survey data that we have from sources like the California Health Care Foundation Health Policy Survey, the California Employer Health Benefits Survey, Medical Expenditure Panel Survey. But there are key pieces of the puzzle missing, especially when it comes to equity impacts.

So, on the next slide, just a couple notes about this. You know, one is that probably other data needs are going to arise as OHCA gets experience monitoring these trends. But we know there's also some key data needs to explore. We would love to get data on premiums and deductibles by race and by income to really explore those inequities and make sure that things are getting better. You know, what data can and should we have by geography?

And we are also excited about the possibilities that the Health Payments Database might open up once that's in full swing.

So just to wrap up here, as I described in the first part of the presentation, we have seen this real decline and affordability of job-based coverage in California over the last 20 years. Health care is eating up a larger and larger share of family budgets. Over the coming years, it will be important for OHCA to measure whether that erosion is continuing. The data collected by DMHC and DOI will be critical.

But tracking is just a first step. If there are disconnects in how health care expenditures are growing and consumer health care costs are changing, the OHCA Board will need to further look into why that is happening and figure out how to address it. We think we have got a real opportunity here. We can learn from states like Massachusetts, which was the first one to have a cost growth target. And they are just starting on this path of tracking consumer affordability. We can start from the beginning, starting with the first OHCA annual report in 2025 and we have some great data to get us started.

So, with that I will conclude and hand it back over to Amanda.

MS. LEVY: Great. Thank you so much, Miranda, for your perspective and for presenting here today, we really appreciate it.

With that, we are now ready to move to public comment. So just want to give a quick reminder to the folks in the room, you can line up at the microphone in order to give public testimony. You will just need to press the microphone to ensure that the light is green and then you will be ready to go. For attendees on the phone -- sorry. For attendees via Zoom, please use the Raise Hand feature. We will give that a minute just as people are coming on. We will

take public testimony in the room first and then we will move to folks on Zoom. For attendees on the phone, if you would like to make public comment please dial *9 and state your name and the organization you are representing for the record.

So, with that we will start with our public comment in the room. Please state your name and organization for the record. Looking at the number. The raised hands looks like they haven't come online. We might limit time but please proceed.

MS. VAN DEYNZE: Thank you. Katie Van Deynze with Health Access California. A dozen years ago, rate review began in California, and sadly this year reports higher rate increases than in most of those years. Consumers are paying more and getting less. What consumers pay in terms of the worker's share of premium for family coverage is now over $6,000, and deductibles are more common and bigger as we heard from the UC Labor Center. Twenty years ago, one in three Californians with employer coverage had a deductible.

Now it is almost 80% and a median deductible is over $4,000. For a family living on a median wage of about $85,000 a year, this means they spent almost $10,400 in terms of worker's share of premium, less the median deductible. How does any family spend one out of eight dollars on health care and still spend on housing and food, not including kids' education and in retirement. And that's on top of lost wages to pay for the employer's share of the premium, which has also been climbing faster than wages, and by one estimate totals $125,000 over the last 30 years. The result is unaffordability leading to consumers not being able to access care when they need it.

Lots of consumers have skipped care when they need it due to the

cost, as we have heard from the Director and a number of the presenters today. And medical debt is climbing, disproportionately impacting low-income Californians and Black and Latino Californians. All the careful work done by the Department of Managed Health Care on equity and quality measures is at risk if consumers can't afford to get regular care and manage their health conditions.

Today began two important conversations about how the data collected by DMHC and CDI on rates can be used as part OHCA's affordability measures, and how OHCA spending targets are tied to rate review. And with respect to the data that DMHC and CDI collect and report on, we look forward to continuing the work and look at the impacts on consumer affordability for consumers with commercial coverage, and especially with employer coverage.

On rate review a couple of key points. First, we will begin asking why a rate increase is greater than the OHCA spending target. And second, we will question any increase in premiums that is artificially lowered by shifting more costs to consumers in the form of higher deductibles, higher copays, and more coinsurance. Again, we are done paying more to get less access to care. The point of the Office of Health Care Affordability is to transform the delivery of health care to lower costs, improve outcomes and improve equity and we look forward to working with all parties on this effort moving forward. Thank you.

MS. LEVY: Thank you. I don't see anyone else in the room ready to offer public comments so we will move to folks on Zoom. We will unmute you once we call your name. First up we have Ian Lewis.

MR. LEWIS: Hi there, Ian Lewis with Unite Here!, the hotel, gaming and food service workers union. Our union sponsors many Taft-Hartley funds around the state. At the same time that SB 546 got going we joined with other

collectively bargained funds to build a health payments database so that we could better understand the price and utilization patterns at health plans we contract with. Today, that database contains over $7 billion in claims, it covers 350,000 covered lives, and 5.6 billion of that spending is through the Kaiser Foundation Health Plan both North and South.

We have got some interesting facts that tie some of your presentations together. Between 2019 and 2022, the cost of medical care through Kaiser increased 2.4% per year on a per claim basis. This is quite comparable to the findings from the IHA Atlas that were presented to the Financial Solvency Board last month, which summarized that HMOs in California kept the cost of care to about 3.1% increases from, in their case, 2017 to 2021. In our experience, just like was shown in your DOI presentation, per member claims volume increased because of COVID and that actually drove aggregate cost of care above 5% per year. Increased utilization seems to have lingered through 2023 but we think that COVID was a one off and hopefully 100 year event. The rub for us though is that what I am citing are raw costs of care. They are equivalent to the allowed amounts, and they are calculated by Kaiser itself. They don't include add-ons for integrated care management fees, pooling charges, and so on, and for that reason the cost of care has very little to do with the premium increases we have had to pay. Premiums have actually gone up 25% faster in some cases than the cost of care and they continue to consume much more money than is available for wage increases or other improvements.

So, I want to urge you as the OHCA spending targets start being phased in next year. You know, one of the big challenges facing OHCA is how to make sure reduced trends accrue to the benefit of consumers; and DMHC has a

critical role to play here. And I urge you to start thinking about how those targets relate to the rate review process, including an especially deeper interrogation not only of pricing trends but also how those add-on fees like integrated care management charges are calculated and justified. Thank you.

MS. LEVY: Thank you so much for your comment.

We will move to Ivana Krajcinovic, but I will encourage others who would wish to get public comment via Zoom to use the Raise Hand feature so we can call on you accordingly. With that, I believe we unmuted you, Ivana.

MS. KRAJCINOVIC: Hi, this is Ivana Krajcinovic, I am with Unite Here Health. We are a national Taft-Hartley trust fund that covers the same group of workers that Ian just spoke to, although in different funds from the ones Ian was speaking about, although our data was also included in the numbers that he talked about.

We were really shocked this past year to receive double digit increases from Kaiser Permanente. We were shocked because in the past we could always rely on utilization reports to provide a clear indication of what our renewal would be, and our utilization had been very low in the experience period. We were also shocked because we pay Ascendant, a third-party data warehouse, thousands of dollars a year to translate the data and validate it and so we were not expecting a double-digit increase. We were shocked because we weren't alone, and as we started talking to other Taft-Hartleys realized that our experience was pretty much the norm. And we were shocked because Kaiser came right out and said they were going to charge us 10% more above what they normally would, and they provided some general rationales like about labor costs and the supply chain, but no real numbers or justification. It was a

complete departure from previous years.

Kaiser dominates the market, and they know we do everything possible to avoid disruptions so we can't just easily switch to a competitor. They set the rates the way they do because they hold all the power. As Ian noted, Kaiser doesn't solve for trend in the traditional sense, they arrive at their own trend and then solve for their own trend. They also have a category of integrated care management fees that are similarly set without a lot of detailed justification. Kaiser no doubt deserves to charge for aspects of their integrated system, but this category for years has been a black box where we suspect many charges just get parked and we can't see or review them in detail.

So, this year we asked for a rate review by DMHC. We hoped that it would show Kaiser that they couldn't just do what they wanted with scant justification, especially given the double-digit increases. We give DMHC staff a lot of credit for spending a lot of time on our review. But DMHC still didn't get enough sufficient detail from Kaiser on how they came up with their own trend nor what their ICM fees are comprised of, so our double-digit renewals stands.

As we enter an era when OHCA will be setting spending targets, it is imperative that DMHC have the ability to fully audit rate renewals, especially when they exceed targets. If a target is in place, Kaiser's process has to conform and if it doesn't DMHC should be empowered to audit and insist on a full explanation. Otherwise, we are going to be right back to where we are now. Kaiser comes up with the number it wants and then back the rates into it and the spending targets that OHCA has worked so hard to establish will be meaningless. Every dollar that we send to Kaiser is a dollar that could have gone to a worker in the form of wages or pensions, arguably doing as much or

more for their health than spending it on health care. We really appreciate OHCA and DMHC's attention to the issue of affordability and we hope that this attention can be translated into real relief for working families. Thank you.

MS. LEVY: Thank you, Ivana.

We will new move next to Harvey McKeon. We will unmute you now.

MR. MCKEON: Hi, there. My name is Harvey, I am from the Carpenters Union. Just a short comment from me today.

Firstly, I want to thank the DMHC for working with our large group plan and, you know, we really appreciated the forthcomingness of staff during the rate review that we also requested in the aftermath of being demanded a double-digit rate increase by Kaiser. Similarly to some of the other commentors I have heard on this call, you know, we were baffled by some of the explanations that Kaiser gave both us and the DMHC with regards to various, you know, X aspects of the rate that they rely on to justify the double-digit increase, including, again, the integrated care management charge. We appreciate the work of Kaiser's frontline health care workers immensely, but we do want some justice in the system. As we go forward, we hope that OHCA's spending target is integrated into the DMHC's review process adequately, and we look forward to continue participating in these public forums whenever they come up. And once again, thank you very much to the DMHC staff for working with us this year. Thanks.

MS. LEVY: Thank you for your comment.

Do we have anyone else in the room who would like to give public comment?

Seeing none, we want to move back to Zoom. I don't see any

raised hands at the moment. Why don't we give it a little bit; we will give it a minute. If you would like to use the Raise Hand feature to offer public comment, please do so now.

I will give one last reminder for attendees on the phone. If you would like to make a public comment please dial *9, state your name and organization that you are representing.

Okay, seeing no further public comment, we want to remind everyone that written public comments may be submitted until 5:00 p.m. on March 20, 2024, to publiccomments@dmhc.ca.gov. Next slide.

I think this is just our closing remarks. We want to thank you all for your time and attention today and your attendance. We are really excited, I think, to see the high attendance virtually, and we want to continue to create a space where we listen and where we can hear the concerns of those in the community. So, with that, again, please submit public comment. You will have an additional week to do so. And we would like to thank you all for attending. Thank you.

(The public meeting concluded at 2:40 p.m.)

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CERTIFICATE OF REPORTER

I, JOHN COTA, an Electronic Reporter, do hereby certify that I am a disinterested person herein; that I recorded the foregoing California Department of Managed Health Care Public Meeting on Health Care Premium Rates and Prescription Drug Costs, and the recording was thereafter transcribed.

I further certify that I am not of counsel or attorney for any of the parties to said Public Meeting, or in any way interested in the outcome of said matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 24th day of March, 2024.

JOHN COTA

CERTIFICATE OF TRANSCRIBER

I, RAMONA COTA, a Certified Electronic Reporter and Transcriber, certify that the foregoing is a correct transcript, to the best of my ability, from the electronic recording of the proceedings in the above-entitled matter.

March 24, 2024

RAMONA COTA, CERT**478