Taxing the Titans? How California's New Office of Health Care Affordability Takes Aim at "Big Health"

Regulatory Update:

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In healthcare policy, the "Iron Triangle" refers to the inherent trade-offs among cost, quality, and access to care. For example, a vibrant marketplace of high-deductible health plans may attract enrollees with the allure of lower premiums. However, these "skinny plans" can subsequently deter patients from seeking essential medical care due to steep out-of-pocket expenses, potentially leading to suboptimal treatment outcomes.

In a parallel vein, the rise of telehealth has streamlined access to clinicians and curtailed incidental costs like travel and time off work, offering particular advantages to rural and economically marginalized communities. Yet, this newfound accessibility risks compromising care quality as remote consultations lack the full range of diagnostic capabilities that in-person visits provide. As such, the Iron Triangle serves as a grounding mechanism, tempering any political or promotional discourse that fancifully promises a healthcare delivery system that is simultaneously inexpensive, universal, and high-quality.

In light of the Iron Triangle, California's current Healthcare Blueprint – adopted in 2022 – warrants skepticism. Advertised under the counter-intuitive slogan "Cutting Costs and Expanding Access," the plan echoes Governor Gavin Newsom's ambitious healthcare promises from his campaign trail. During his campaign for Governor in 2019, he presented an aggressive healthcare agenda targeted at achieving the trifecta of affordability, accessibility, and high quality. Newsom pledged to tackle soaring prescription drug prices and explore avenues for universal healthcare coverage, drawing inspiration from a range of systems—whether single-payer models like those in the UK and Canada or multi-payer setups as seen in France, Germany, and Israel. However, these models are usually funded by a mix of high consumption taxes and Value-Added Taxes (VATs), which range from 15-25%, and/or income tax rates as high as 40-50%, a level of fiscal commitment that most Californians would find unacceptable. This fiscal dilemma compelled Newsom and other legislators with similar ambitions to seek alternative, politically viable funding avenues that would not alienate the tax base. It was against this backdrop that the Office of Health Care Affordability (OHCA) was established. Making a strategic departure from the notion of taxing already burdened individuals and employers, the OHCA focuses on scrutinizing large healthcare participants, such as hospitals and managed care organizations, with the goal of identifying untapped potential for savings and funding.

The concept for California's Office of Health Care Affordability (OHCA) first emerged in the legislature in 2020, introduced as Assembly Bill 2817 (AB-2817), which ultimately stalled. While the Covid-19 pandemic was cited as the formal reason for setting aside the bill, it's probable that unpublicized resistance from the industry had a meaningful impact as well. Nevertheless, the idea was resilient, and by 2022, the proposal had evolved and successfully passed into law (SB-184), outlining an expansive set of goals and responsibilities for the OHCA when it opens in 2024, which is worth quoting in part:

"The bill would require the office to monitor cost trends in the healthcare market and to examine healthcare mergers, acquisitions, corporate affiliations, or other transactions that entail material changes to ownership, operations, or governance of health care service plans, insurers, hospitals or hospital systems, physician organizations, providers, pharmacy benefit managers, and other health care entities."

The bill's expansive mandate led one critic to label the office's powers as "Orwellian" in scope. In essence, the newly proposed office is designed to act as a central controller in the healthcare landscape, superseding traditional free-market forces that have historically dictated costs, from insurance premiums and prescription medications to routine office visits. It's a radical shift from the conventional market dynamics that have been shaped through negotiations among insurers, healthcare providers, and patients. In the long run, its Investigations and Enforcement Branch is expected to fully staff up with legal professionals and contractors to initiate penalties for non-compliance.

The OHCA is also intended to act as a counterbalance to the prevailing trend of healthcare consolidation. Rather than letting industry participants seek efficiencies and cost savings through mergers and acquisitions on their own terms, this office will have the ultimate authority to determine what constitutes efficiency and cost savings.

Here are some key regulatory milestones to consider:

By **April 1, 2024,** healthcare entities must notify the Office of Health Care Affordability (OHCA) at least 90 days in advance before entering into agreements related to mergers, acquisitions, leases and other material disposals of assets. This mandate will apply broadly, encompassing hospitals, pharmacy benefits managers, nursing homes, and even large physician organizations consisting of 25 or more members.

Come **September 1, 2024**, insurance payors and fully integrated healthcare delivery systems are mandated to submit their total healthcare expenditure data for the years 2022 and 2023 to the OHCA. To facilitate this, the office is in the process of setting up data portals, and eventually, there might be a requirement to submit such cost data on a monthly basis.

In **2025**, based on the collected data, the OHCA will establish the first set of statewide healthcare cost targets.

Starting in **2026,** the OHCA will actively enforce compliance with these cost targets, and organizations that fail to meet these targets will be subject to corrective actions or escalating administrative penalties.

The immediate ramifications of this legislative framework will likely include a scramble to expedite pending deals to ensure they come into effect before the April 1, 2024, deadline. Over the long term, the healthcare industry is liable to invest more in compliance resources, which will invariably inflate administrative costs. This burden will likely weigh more heavily on smaller industry participants. Drawing a parallel to the banking sector after the 2007-2008 financial crisis, increased compliance pressures led to the disappearance of smaller, local and regional banks. Similarly, rather than fostering increased competition in healthcare, these new regulatory constraints might actually serve to limit it.

The pivotal question remains: Will the Office of Health Care Affordability (OHCA) succeed in making healthcare more affordable? The OHCA takes its cue from similar commissions in four other states. These commissions set price targets for individualized medical treatments as well as general per capita spending. However, it's notable that in all four states—Massacheusetts, Rhode Island, Delaware, and Oregon—healthcare expenditures have consistently outpaced their established benchmarks. Ultimately, the Iron Triangle of healthcare seems inescapable; providing high-quality care for all invariably comes at a high cost.

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