HCAi Department of Health Care Access and Information
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Health Care Affordability Board
December 19, 2023
Public Comment

The following table reflects written public comments that were sent to the Office of Health Care Affordability email inbox.

Date	Name	Written Comment
12/19/2023	Jenn Engstrom	My name is Jenn Engstrom and I'm the State Director of CALPIRG, the consumer group. We represent Californian consumers across the state and know from engaging our members that health care costs have gotten out of control, with 44% of Californians reporting delaying or skipping care due to cost. In California, health insurance premiums for employer coverage have increased by 249% between 2002 and 2017, six times the rate of general inflation. We need to get control of costs to ensure people can afford the care they need. We generally support the Office of Health Care Affordability's staff recommendations and want to thank the staff for your work on this effort. We strongly support using the median income as the basis for the spending target because it comes closer to capturing what Californians can afford than the wealth of the economy. And we thank you for getting rid of the phase in beyond what is already built into the law. However we encourage making the growth targets even lower because of the lack of affordability today. People are struggling now and we need to get control of costs to make sure people can get the care they need. Thanks you. Jenn Engstrom State Director CALPIRG and CALPIRG Education Fund
01/17/2023	Meron Agonafer	Dear OHCA Board, As you are aware, Black Californians are struggling to keep up with the ever-increasing healthcare costs. As an

		organization committed to advocating for equitable access to quality health care, CBHN believes the OHCA Board should adopt a spending target based on median income since it better captures the capacity of Californians, particularly those Blacks and other marginalized communities, to afford their health care expenses. The current high inflation rates exacerbate the financial troubles Blacks face in California, making it even more challenging to meet the rising healthcare costs. As an instrumental authority in the healthcare sector, we urge the OHCA Board to adopt the median income as a spending target to reduce the current exponential growth in healthcare expenses to alleviate the further suffering experienced by the Black community and ensure access to healthcare without undue financial burden. We appreciate your attention to this matter and look forward to your proactive efforts in reducing healthcare costs and promoting equitable access for all Californians. The California Black Health Network (CBHN) is the only Black-led, statewide organization dedicated to advancing health equity for all African Americans and Black Immigrants. ***Meron Agonafer*** Policy and Legislative Affairs Manager California Black Health Network, Inc.
01/17/2023	Beth Capell on behalf of Health Access California	See Attachment #1.
01/18/2023	Ben Johnson on behalf of California Hospital Association	See Attachment #2.

HEALTH ACCESS CALIFORNIA

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January 17, 2024

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

Elizabeth Landsberg, Director
Department of Health Care Access and Information

Vishaal Pegany, Deputy Director
Office of Health Care Affordability
Department of Health Care Access and Information

2020 W. El Camino
Sacramento, CA 95814

Re: December 2023 Health Care Affordability Board Presentation,

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

Health Access California, the statewide health care consumer advocacy coalition, committed to quality, affordability health care for all Californians offers comments on the discussions at the December 19, 2023, Health Care Affordability Board meeting.

Health Access strongly supports the recommendation of staff that:
Basing the target on historic median wage "signals that spending on health care should not grow faster or take up a greater proportion of the income of Californians than it currently does."
This statement reflects the objective of the underlying law as well as the reality of California consumers. Health care in the United States costs three or four times as much as in other wealthy countries. Only in the U.S. does the dominant form of coverage, employer coverage, inflict the greatest costs on those who can afford it the least and those who need care the most[1].

Health Access proposes the following with respect to the initial statewide spending target:

- A statewide spending target of 3.0% based on a 20-year rolling average of California median income for the period 2003-2022[2].

[1] One of numerous studies: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.01566
[2] Private communication from UC researchers re 20-year rolling average of California median income for period 2002-2022.

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- A target that is in force for five years with annual reviews.
- No adjustment by period or exclusion of particular years based on economic circumstances without regard for worsening affordability of health insurance premiums, copays and deductibles. Smoothing is accomplished by a long time period rather than the arbitrary exclusion of particular years.
- Inclusion of measures of consumer affordability measures in the baseline and annual reports, including premiums, actuarial value, and cost sharing.

The point of OHCA is to stop the worsening of health care affordability, not lock in place the ever-escalating costs of the health care system. The triple aim of lower costs, better outcomes and improved equity is embedded in the OHCA law from the emphasis on primary care and behavioral health to measures of access, equity, quality and workforce and more. California has many opportunities to reduce health care costs while improving equity and quality: examples of low-hanging fruit include improving vaccination rates for flu and Covid, reducing hospital acquired infections leading to shorter hospital stays, reducing readmissions, and eliminating unnecessary administrative overhead at all levels of the health care system.

Spending Target Proposal

Health Access supports a spending target based on the California historic median income for the period 2003-2022, which averages 3.0%. Health Access does not support differential weighting of different time periods or exclusion of time periods. The great recession of 2008-2010 did result in a decline in income but that occurred at the same time health insurance costs continued to climb by double digits in terms of both premiums and cost sharing such as copays and deductibles. The decline in income during these years made consumer affordability worse, not better.

The recent report on economic indicators, What Can We Afford? Aligning Office of Health Care Affordability spending target with Californians' ability to afford increases (berkeley.edu) included exhibits on:

- Annual rate change of key economic indicators (exhibit 7)
- Percentage of annual change of key economic indicators (also exhibit 7)
- Three year rolling average (exhibit 8)

After reviewing these, this report recommends a 20-year rolling average. Both Oregon and Washington State which use historic median wage also use a 20-year rolling average. After reviewing these options, we also support a 20-year rolling average.

We support having this target in place for five years to allow time for health care entities to come into compliance and time to reduce costs while improving outcomes and equity. Health Access opposes an even longer phase-in period in addition to the five-year period codified in law. OHCA was enacted in 2022, after several years of Governor's budget

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proposals and legislative debate, and years after AB 3087 of 2018 proposed a much more stringent approach to regulating health care costs. Delaying implementation of the spending targets even further does nothing but worsen the damage to consumers.

Health Access appreciates the staff decision to include measures of consumer spending and looks forward to further discussion of such measures, as well as further development of reporting as needed.

Adjustments: Statewide Spending Target

Technology: At this time, Health Access does not support adjustments to the target based on technology. In addition to the points made by staff about the technical difficulties of measuring the impact of technology, we agree with Board Member Elizabeth Mitchell that many technological changes are supposed to improve care, save money, or both. Examples may include electronic health records and health information exchange, which improve timely access to appropriate care while eliminating avoidable overhead, if correctly implemented. Faxes and paper records should be a thing of the past in health care as they are in most other parts of the economy.

Population Adjustments: Health Access supports the staff recommendation that the statewide spending target should not be adjusted for population-based measures. We distinguish between the statewide target and individual health care entity targets or enforcement of the statewide target with respect to individual health care entities or sectors. The review of the literature and the experience in other states persuades us that population adjustments are not appropriate for the statewide spending target.

Spending Target Adjustments: Potential Process for Health Care Entities

The enabling statute for the Office[3] has several provisions on adjustments or potential adjustments to cost targets for sectors or individual health care entities. Each of these provisions has important implications for the work of the Office and the Board. We look forward to a longer discussion of enforcing statewide spending targets for sectors and individual health care entities as well as discussion of adjustments at the individual entity or sector level.

Health Access offers principles for the process for adjustments for individual health care entities. The process of considering and adopting adjustments should include all of the following:

[3] Health and Safety Code 127502 (d) (6) and (7), (e), (f) and (g). Section 127502 (d) (5) also permits adjustments to take into various aspects of the Medi-Cal program including both those that maximize federal financial participation and those that affect the amount and level of payment to Medi-Cal providers.

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- The adjustment should advance the OHCA goals of protecting or improving access, equity and quality while reducing costs,
- The exception should not swallow the rule: adjustments should not make meaningless the spending targets or the underlying triple aim of lower costs, better outcomes and greater equity.
- The process and the standards for adjustments should be public and transparent
- The adjustments should be known and knowable in advance, barring unexpected developments such as an expensive new drug like Sovaldi or once-in-a-century pandemic,
- The process should be informed and revised based on OHCA's experience with implementation and the experience of cost commissions in other states such as the example of Massachusetts with upcoding,
- The process should be aligned with carrier rate review as well as contracting for major state purchasers, including Medi-Cal, Covered California and CalPERS,
- Adjustments should be made within a time-limited duration with regular review of the continued appropriateness of any adjustment and reversion to the statewide target when costs come more into alignment with that target,

The law is clear for some factors affecting individual health care entities: OHCA must make adjustments based on social determinants of health as well as labor costs for organized labor, which are based on contracts referred to as collective bargaining agreements. For other factors, OHCA has discretion as to whether and how to adjust. For example, for risk adjustment based on patient mix of an individual entity, the law allows OHCA to take into account both the incentive to drop or avoid high-cost populations as well as the perverse incentive to up-code clinical status.

We look forward to further discussion on adjustments and enforcement against specific health care entities.

Summary:

Health Access supports setting a cost growth target that limits the rate of growth and encourages health care entities to seriously pursue the triple aim rather than ignoring the consequences of unaffordable health care for the bottom 80% of the income range for Californians.

Californians cannot afford the existing health care system. The median income for Californians is now about $83,000 a year while health insurance premiums for family coverage are about $24,000 a year. This is unaffordable. Roughly 80% of Californians were projected to make less than $150,000 a year in taxable income in 2023[4]. The reality of

[4] Weakening the SALT Cap Would Make House Tax Package More Expensive and More Tilted in Favor of the Wealthiest – ITEP

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health care costs, incomes and housing prices has often been demonstrated by public testimony at the Board, from Monterey, from small businesses, from those Californians with multiple sclerosis and other conditions.

Health Access supports a spending growth target based on a 20-year rolling average of median income for the first five years of the target, with annual reviews. Health Access appreciates the staff proposal to include consumer spending in the baseline and annual reports so that health care affordability does not continue to worsen, and consumers are better able to afford other needs, from housing and food to education and retirement.

Thank you for your consideration of these comments. Please contact us with any questions,

Sincerely,

Beth Capell, Ph.D.
Policy Consultant

Anthony Wright
Executive Director

CC: Members, Health Care Affordability Board
Assemblymember Robert Rivas, Speaker of the Assembly
Senator Toni Atkins, Senate President Pro Tempore
Assemblymember Mia Bonta, Chair, Assembly Health Committee
Senator Susan Eggman, LCSW, Chair, Senate Health Committee
Assemblymember Jim Wood, D.D.S., author

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California Hospital Association

January 18, 2024

Mark Ghaly, MD
Chair, Health Care Affordability Board
1215 O St.
Sacramento, CA 95814

Subject: **Urge Serious Scrutiny of the Proposed Spending Target and Significant Changes to Avoid Negative Consequences**
(Submitted via Email to Megan Brubaker)

Dear Dr. Ghaly:

The Office of Health Care Affordability (OHCA) has an obligation to improve the affordability of health care **without sacrificing access to or the quality of health care**. While the office is clearly committed to the first goal, its final recommendation for California's first statewide spending target misses the mark on the second goal — putting patient care in jeopardy.

On behalf of our more than 400 hospital and health system members, the California Hospital Association (CHA) urges the OHCA board and advisory committee to reconsider OHCA staff's proposed 3% target for 2025-29. We specifically are concerned that the proposal:

- Fails to strike a balance between promoting affordability and maintaining access to high-quality, equitable care
- Ignores external factors that influence health care costs, such as inflation and California's aging population
- Sets California apart as an outlier from other states with spending targets

Proposed Spending Target Fails to Strike a Balance Between Promoting Affordability and Maintaining Access to a High-Quality, Equitable Health Care System

While establishment of a spending target is intended to promote affordability, that is not the only goal. State law clearly requires the spending target to be set in a manner that preserves high-quality, equitable care. OHCA's proposed spending target is:

- Incompatible with the spirit, if not the letter, of state law, as a sudden 40% drop in the growth in health care spending, in the current inflationary environment, is not achievable without serious negative consequences for patients
- Arbitrary and lacking consideration of the underlying drivers of health care costs

- Devoid of proper evaluation of its likely impacts on access to high-quality care

Ultimately, this spending target — if finalized as proposed — would significantly harm patients across California.

Proposed Spending Target Fails to Consider the Reasonable Costs of Operating a High-Quality Health Care System

OHCA's proposed target entirely ignores the drivers of health care spending. In doing so, it would force health care providers to significantly cut back on the care they provide or face penalties. To avoid this negative outcome, OHCA must recognize at least the following four essential components when setting a spending target:

- **Inflation.** Over the next five years, the Legislative Analyst's Office projects inflation to be 3.5% annually. In other words, OHCA's proposed spending target would dictate a decline in real health care spending of 0.5% over time, assuming no change in utilization despite the growing health needs of California's population and concerted efforts, in Medi-Cal and beyond, to improve access to care. Hospitals and other providers would find themselves not only unable to afford medical supplies and infrastructure updates, but also hamstrung in their ability to compete with other states and sectors for workers.
- **Growing health needs of an aging population.** The Department of Finance projects California's 65 and over population to grow by 13% (over 900,000 people) between 2024 and 2029, while the under 18 population is projected to shrink by nearly 6% (over 500,000 people). In fact, the 85 and older population is projected to grow the fastest, by 17%, over the same time period. Health care costs for seniors are five to nine times those for children and youth. Aging alone is projected to increase health care spending in California by 0.7% annually, a far greater impact than what OHCA staff presented, and yet another factor unaccounted for in OHCA's proposed spending target.
- **Health care policies that drive up costs.** Policies adopted by the Legislature — such as the dedication of new tax revenues to raise Medi-Cal reimbursement rates and the enactment of a health care worker minimum wage — will add billions of dollars in health care spending once fully implemented. In fact, these two recent policy changes, on their own, will raise health care spending by over 2% in tandem over the next several years. The proposed spending target does not accommodate these or any other changes enacted by policymakers.
- **Facilitation of thoughtful, meaningful change.** For the spending targets to be effective in promoting affordability without harming access, quality, and equity, health care entities will need to make new investments and change their care processes to shift toward value-based care. While this has the potential to lead to long-term cost savings, it requires significant up-front investment and will not produce cost savings overnight. By setting a flat, multiyear target, OHCA has failed to recognize the time needed to truly improve the value proposition of health care. Instead, in effect, OHCA is encouraging the hasty slashing of costs. Patients will bear the brunt of this, as health care entities would be left scrambling to cut their spending growth in the fastest ways possible: closing

service lines, reducing workforce, not offering the latest drugs and medical technologies, and curtailing investments in their infrastructure and care processes.

Proposed Spending Target Is an Outlier Among Other States

Spending target programs have been implemented in eight other states. As the figure below shows, ***California's proposed target is lower than all other states'*** when considered on a multiyear basis. In fact, while the other states set their targets to exceed the historical growth in their economies by about 1 percentage point (or 45% higher) on average, OHCA's proposed target would be nearly 2 percentage points (39%) lower than California's historical economic growth rate. Moreover, inflation in the year prior to the other states setting their target averaged a mere 1.8%, whereas for California, prior-year inflation came in at 4.2%. This factor is entirely unrecognized in OHCA's proposal.

California's Spending Growth Target Would Be the Lowest in the Nation Despite Higher Inflation and a Faster Growing Economy

State	Year Target Was Set	Average Target	GSP Growth	Difference (Target - GSP)	Prior Year Inflation
California	2024	3.0%	4.9%	-1.9%	4.2%
Massachusetts	2012	3.1%	2.5%	0.6%	3.1%
Nevada	2021	3.1%	2.9%	0.2%	1.3%
Connecticut	2020	3.2%	1.2%	2.0%	1.8%
Rhode Island	2021	3.2%	1.3%	1.9%	1.3%
Washington	2018	3.2%	4.7%	-1.5%	2.1%
Delaware	2018	3.3%	0.4%	2.9%	2.1%
Oregon	2021	3.4%	3.2%	0.2%	1.3%
New Jersey	2021	3.5%	1.7%	1.8%	1.3%
Average Among Peer States		**3.3%**	**2.2%**	**1.**	**1.8%**

GSP = average gross state product for the period 2016-2019.

Average Target = average growth in the health care growth target 2021-23 (for states other than California).

Main Source: Melnick, Glenn. CHCF Issue Brief, Health Care Cost Commissions: How Eight States Address Cost Growth. April 2022.

OHCA's Proposal Is Incompatible With the Health Care System Californians Need and Deserve

California's health care system provides world-leading, life-saving care to millions of patients every year. It employs 1.7 million highly skilled and specialized workers, and hospitals generate more than $343 billion in economic output annually. A poorly considered, hastily developed cost growth target would have dire consequences for millions of Californians — the importance of a thoughtful, data-driven approach cannot be overstated.

OHCA has an historic opportunity to transform California's health care system in a meaningful way, allowing it to progress toward the system patients so crucially need. To strike the right balance between cost savings and preserved access to high-quality health care, the board must critically evaluate the methodology underlying the proposed target, seriously consider whether it meets the spirit and letter of state law, demand a robust and multifaceted rationale to support a final target methodology, and ensure the impact on patients is thoroughly understood.

Sincerely,

Ben Johnson
Vice President, Policy

cc: Elizabeth Landsberg, Director, Department of Health Care Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability
Members of the Health Care Affordability Board:
David M. Carlisle, MD, PhD
Secretary Dr. Mark Ghaly
Dr. Sandra Hernández
Dr. Richard Kronick
Ian Lewis
Elizabeth Mitchell
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