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Health Care Affordability Board
February 28, 2024
Public Comment

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

Date	Name	Written Comment
2/16/2024	Wendi Raw	I am low income and turn 60 this year. I am still well below the median income for my city, but since I started to get a small retirement payment after my mother died last year, I saw my healthcare costs go up by so many hundreds of dollars that I had to opt to have only catastrophic health care coverage for 2024. There are things I shouldn't neglect that are being watched by doctors, but this year I won't be able to go to the doctor unless I pay for it out of pocket, which I cannot afford. That's just one of quite a few stories I could tell throughout my lifetime. Even with Obamacare, the cost is too much for many of us. The insurance industry has inflated the marketplace so much since it began that in recent years I payed much more than I used to when it was entirely out of pocket- even with the same income and the new government subsidies. It's ridiculous.
2/27/2024	Craig Simmons	According to the U.S. Bureau of Labor Statistics sixty percent of the U.S. population are employed or self-employed. With California's population of forty million, twenty-four million people are employed. Leaving Medicare, Medi-Cal, private, and employer provided health insurance in place, a payroll healthcare tax of $.25 cents per hour would accrue $6 million per hour into the state treasury based upon a 40-hour work week. A voter approved payroll healthcare tax would provide all California residents and their families with enough to cover preventive care, surgeries, prescription drugs, behavioral healthcare including addiction treatment, outpatient services, and potentially long-term care for a $ 2.00 per day or $40.00 per month payroll deduction. Voluntary sign-ups at hospitals and community

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		health centers would entail a multiphasic health exam to establish a database for patients throughout the state. Treatment could be performed at any hospital or urgent care center. Standardization of healthcare costs is key to establishing healthcare equity. A single-payer system would allow for uninsured and under-insured populations to receive quality healthcare by simply signing up for the program. Physicians and nurses' salaries would be standardized, as would prescription drug prices. California's Office of Healthcare Affordability estimates that within the next few years, healthcare costs will rise to $531 billion annually. There is still time to place a referendum on the November ballot to allow voters to decide.
3/05/2024	Health Access California	The following public comments were transcribed from videos submitted for your consideration and review: 1. Vicki Vellegas Good afternoon. My name is Vicki I'm here to share with you my story of have been multiple sclerosis. So a little bit about me. I am 43 years old. I come from a family. I'm the third of seven. I grew up in southeast Los Angeles. I faced issues as a little child such as poverty and food and insecurity. So I decided to go to college and I worked my way up and I'm a nurse practitioner now. I was diagnosed with M.S. June 22nd, 2017. I have two young daughters, their ages 11 and 13. So of course, this changed my world forever. I immediately went out to look for a top neurologist and I took her recommendation to start the disease modifying treatment. Crevice, which I did receive as an infusion twice a year for every six months. I was just very surprised when I got the bill for the infusions. My co-payment was $3,000 for it and this covered the medication and the infusion center which was used to infuse the medication. I wanted to keep getting the best medication, but it did make a significant financial strain on my family life. I was the sole breadwinner at that time and at that time I didn't know what to do because I wanted the best medication. I wanted to make sure that I was okay for my children. Sorry, I don't mean to get emotional. So I started working more and I think at one point I did work up

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		to four jobs between working in the clinic teaching and I was doing too many jobs. So eventually my health did to you because of the added stress. And to date right now I suffer from lopsided weakness in my arm and my foot, my leg. Sorry. And I'm unable to do most of the things I love to eat, like running or riding a bike. Just different hobbies that I've had to pick up. So I'm here today because the Office of Health Care Affordability does have the power to influence these high co-payments for you to please continue to pay. And I think that even as my experience as a provider, we want to give our patients the best treatments that are available and not have cost be such a barrier to receiving these wonderful treatments for different diseases that are affecting our citizens. Thank you. 2. Princess Sims Good morning and happy holidays. My name is Princess Sims. I am one of the owners of the Final Sauce, a specialty condiment company located here in Richmond, California. We have been in business a little over five years. And the idea of future employees health care cost all the costs associated with having employees incentive packages for all, in case all those things have been in the forefront of my mind since I've been here in 2016, running the business with my sister. We're a small business and we don't have the access or the financial resources available to us as a small business that larger companies have. They have access, they have resources available to them, to hire employees, offer a great incentive package, to help run their business. As we grow, we absolutely will have to take in consideration of hiring employees. And in doing that, we'll have to take the financial implications of that in consideration. So health care costs, workman's compensation, insurance, possibly for one K, all those things come together to as an incentive package to offer to to and a potential employee to come and work for us. So absolutely, it's a consideration and we're trying to figure out how how we're going to be able to do that in the future in order for this business to grow. On the other issue with my own health care expense expenses, I have a lived experience. Right now, my medical insurance through my employer and well, I pay a little over $100 every two weeks for my

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		medical care. So we're looking at closer to 250 to 300 a month. That comes out of my check. I still have to pay a co-pay. I pay for my medications because I do have chronic illnesses. I have to, you know, stay in appointments for, wellness checks and I might not have to do that. And as a woman, I have to do my wellness checks as I get older. These things have to be done and there's a cost to that. And then there's emergencies. Last year, I stepped on a needle and broke it in my foot and I had to have surgery. The cost of that surgery was $400 they want At the time when I showed up for the surgery, they want additional $400. They did the surgery. They took care of me. But that's a medical bill that I owe on. So if I have an employee that has a similar experience and that's a bill they have to owe, that is a financial burden on top of them that they have to they're going to have to contend with. So, you know, if I don't offer a benefit package and there's no medical insurance for them for emergencies or things that happen, I mean, this is just life. These things happen and are unavoidable. How does that affect them? How does it affect me? As a small business owner? I want, you know, the I look, you don't offer a great benefit package. I'm going to go over here because they offer a great benefit package. Those things weigh heavy on me as we move forward and grow the business. Thank you. 3. Kristin Horowitz Hi there. My name is Kristen Horowitz. I'm the mother of twin girls in second grade. I have a lovely husband, many pets, and I really love living on the Central Coast of California. But most importantly, you know, I'm the CEO of the Pad climbing and an employer of nearly 100 people. If you're not familiar with climbing gyms, we are an economic driver. We're sort of your third space between your workplace and your home or school space. And it helps people go there, not just to go climbing for kind of a fun one off thing, but they become really integrated there. They make their friends there. They have really deep conversations and they see themselves in different ways. So we've seen a number of businesses, incubated relationships formed and employees develop to the way that they want to so they can go on to do more things in the 20 years that we've been running the company.

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		We've actually won a number of family and employee friendly awards reflecting that and very proud of that. One of the things that we do is have very generous paid time off. We exceed the requirements both by the state and federal level. And actually we allow our full time employees as much full time off as they need to get their things done as long as others agree to take on the load. So family leave, maternity leave, mental health, etc.. We basically say, look, we're a rock climbing gym. Our priorities are your hobbies, your life, and we want the best of you and you show up. So please take your time on the. The problem with this obviously comes with when people are injured or sick, they're not showing up and giving us their best because they're ill. And I'm about to give you some more stories. We actually supply silver level PPO plans for all of our full time employees, and that includes dental vision. And we also provide a 100 enrollment stipend monthly. So they're able to prioritize whatever care they need when they need it. But I'm about to tell you some sob stories, and the gist of it is this: About 10% of my employee salary is what I pay for their health care premiums. So if I pay, for example, $50,000 to somebody, it'll be $500 a month for me to pay for them. So it's it's really a lot of money that they don't see coming forward so that when we have very low pay, we have to point out that we have all these premiums for them and they don't really see value for it, especially if they are hurt, right or ill. I wanted them to have security of health care when they work for me, but it means that we really can't pay very much. And so an employee asked to go above that. We cannot go about that, remain profitable enough to keep our shareholders happy. We're not a huge company. We don't have like whatever the stereotype of greedy shareholders is. But the issue is, is that obviously the cost of doing business in California is very high. You know, we have a lot of regulations, insurance on the liability front is getting higher and higher. And basically the pay that we have, about a third of it or more goes to rent or housing. So when deductibles are more are 10% or more of people's take home pay and they're not covered by the company because we can't afford to. It's hard to find space to get much needed care when it arises. I maintain, health care for my family

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		through our company's employer plan. And it cost my business over $24,000 a year for the four of us. That's one third of my take home salary at the company. And that's because of that. We're in the same boat as everybody else that I'm talking about. Just by being the owners of the business and being in the business for 20 years, we don't make that much money. And my husband, I have to carefully plan who gets health care each year and time it with those calendars, Right. Barring emergencies. COVID policies when the girls were in school requiring doctors notes were particularly hard because we don't have a lot of doctors available to take time to get that. But beyond that, the cost of a visit just to get the letter was really problematic initially, until the top department of my full time employees on the headquarters team, three out of the four women with children have lost over 50 working days this year due to their own illness or their children and their inability to quickly resolve their issues due to being unable to afford co-pays and prescriptions without carefully saving for them. Which again, very difficult to say if you're in our situation, if they work for a typical company, they'd no longer have a job or steady pay and they end up on welfare. And of course this cuts into my bottom line in lost productivity, and I'll move on to that a little bit more in a minute. As a hiring manager, we're actually provided a chart each year that shows the increase in fees as the individual ages. I have to think that as a health care goes up, the more in the age that it actually has to be a factor in layoffs and not hiring older individuals. The premiums are one enrollment guide that I looked at before I did this reporting. Less than 18 year old, $360 a month and a six year old of 1072. That's a major hit for a company with a workforce. So I can see that despite there being laws against ageism, it be very difficult to bring on somebody with a lot of experience or retain one when you're needing to find a way to account for all the costs that are increasing. California as an employer. The other thing that really bothers me about all of this is that I know that many of my employees are somewhat forced to commute to work for me solely to maintain their benefits. I've had one employee out for two months so far that I've been carrying her workload as well as some other people, and she's super grateful to be able to

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		take care of her and her child's health issues. But you know what? She can't leave me because nobody else would retain her as long as she did with those benefits and make sure she has insurance. She doesn't know how she's going to be able to make the deductibles and the out-of-pocket expenses. I can't afford to raise her, but she's kind of stuck there. And so there's this horrible cycle of I get injured, I can't afford the deductibles and I can't afford the out-of-pocket, but I can't leave my company and make more money because they can't afford to give me more money. But I also can't leave it because I need those benefits. It's it's a really rough situation. If they got out from under me, they'd either go on to the state system or they'd get saddled with the burden of insurance premiums on themselves. I actually prioritize higher hiring people in situations where they need the flexibilities and a lot of working moms or single moms, and they're all in these kind of situations. And so if we're looking to invest in our workforce to benefit our economic betterment, kind of forcing people into these situations where they can't get beyond where they are is a major problem. And health care is a big part of that that we can actually affect. So for all of these reasons, I hope that these lived experiences can help you find a solution so that all of us can continue to live, innovate and thrive in California without the threat of bankruptcy due to health care costs and time lost. Have a good one. 4. Raul Salazar Hola a todos y a todas. Mi nombre es Raúl Salazar y vivo en Salinas, California. Por este medio quiero contarles mi experiencia con lo caro que sale ir al hospital en el Condado Monterrey. Mi esposa tuvo un ataque al corazón que fue llevado a la sala de emergencias que Han realizó una cirugía de emergencia y la mantuvo por una noche en el ICU y luego transfirió a California Pacific Medical Center, donde pasó otra semana en el ICU. La cirugía y la estadía de una noche en Champ costaron alrededor de 506.000 $. Más de medio millón de dólares en 24 horas. Algunas personas dicen que los precios de Champ son altos porque tienen un alto nivel de tensión. Pero Champ no pudo cuidar a mi esposa después de su cirugía, tuvo que enviarla a San Francisco. Esto fue una

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		emergencia, así que no tuvimos tiempo de buscar otro hospital. Champ es el único hospital en nuestra área y está aprovechándose de nosotros. Tengo suerte de tener un plan de seguro xenical que pagó casi toda la factura. My porción está limitada a 6.250 $. Que sí, Siento mucho dinero. Gracias por escuchar. Necesitamos ayudar para tener ese tipo de abuso. Y todos. Mi nombre es Raúl Salazar y vivo en California. Por este medio quiero contarles mi experiencia con lo caro que sale ir al Hospital del Condado de Monterrey. Mi esposo tuvo un ataque al corazón y fue llevado a la sala de emergencias. Champ realizó una cirugía de emergencia y la mantuvo por una noche en el pasillo y luego la transfirió a California Pacific Medical Center, donde pasó otra semana en el pasillo. La cirugía y la estadía una noche en Champ, costando a través de 576.000 $. Más de medio millón de dólares en 24 horas. Algunas personas dicen que los precios de Champ son altos porque brindan un alto nivel de atención. Pero yo no puedo creer mi esposa después de la cirugía, tuvo que enviarla a San Francisco. Esto fue una emergencia, así que no tuvimos tiempo de buscar otro hospital. Champ es un único hospital en nuestra área y están aprovechándose de nosotros. Tengo suerte de tener un plan del seguro xenical que pago casi toda la factura. Mi porción estaba limitada a 6.350 $, que sigue siendo mucho dinero. Gracias por escuchar. Necesitamos ayuda para detener este tipo de abuso. 5. Heather Ballinger My name is Heather Ballinger. I am a registered nurse in San Francisco, California, and I've been working as a registered nurse here for 16 years. In 2018, I was diagnosed with breast cancer, and was lucky that it was caught early. My prognosis was very positive. Minor surgery and a few rounds of chemotherapy and some radiation. And I was going to be back to business. I was going to continue receiving one particular chemotherapy agent as a monthly infusion for a year. And the purpose of this was that the specific type of cancer I had had a high rate of recurring as an aggressive cancer and metastasizing quickly and this particular medication had a great record of stopping it in its tracks. And so I was proceeding with my treatment again, very luckily fully insured.

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		And received the first summary of my health care costs. Those were not the costs I paid, but they are the summary of costs of the bill, and the infusion for this one medication, one infusion, for an hour and a half, was $12,000. And I remember. . . I remember standing there and looking at that and feeling so guilty. And just the thought going through my head, I, I get to live because I'm well insured? I'm going to receive this infusion 11 more times and it's going to cost $12,000 every time. So does that mean somebody that doesn't have $120,000 or good insurance just dies? I just, I had such a strong response, that just I felt so much guilt that someone could have to make a choice like that because they didn't have insurance. And I think that one obviously, that one still hurts a little bit because I don't understand. I just don't understand. 6. Doug Long Hi, I'm Douglas Long, and I'm a registered nurse and R.N. working at San Quentin State Prison. Well, now it's San Quentin Rehabilitation Center. I was working as a nurse, as an R.N. in a hospital when I had a shoulder injury that required a surgery. The surgery was a cost $15,000. I had health care insurance. My employer, the hospital, actually had me covered with Blue Cross Insurance. So I ended up having the surgery - $15,000 out of that $15,000, insurance company paid about $1,500. I ended up paying out of pocket $13,500 for a procedure that was actually supposed to be covered by my insurance company. Now, when I protested this, the insurance companies said, there is a clause in the contract that says they can pay whatever they want. In other words, they can just pick what they choose to pay back. So I took this to a small claims court and the judge said, Yeah, it's in the contract. The insurance company, the health care trust company can pay whatever they want or in other words, as little as they choose. And there is nothing that I could do about it. So ironically, I actually ended up paying more to the health care and to the health insurance company in premiums than I would have if I had no insurance. In other words, it cost me more money to have health care insurance in this case than if I had no health care insurance at all. Now, look at the irony of this.

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		I'm a nurse working in a hospital and yet and I was covered by health care insurance. And yet, even with all of that in my favor, I was still hit with a $13,500 bill that was out of pocket. Now, you know, I have a job, so I'm okay. But imagine if it was most other people, a $13,000 bill for something that should never have occurred because you think, 'Oh I have health care coverage. I should be okay.' Even with health care insurance, you could still be hit with a bill that for most people in California would be devastating. It would be a financial disaster. Now, this shoulder surgery was necessary for me to be able to do my work as a nurse in the hospital. So in other words, if I had not had the surgery, I would not be able to work. This was a necessary procedure for me to be able to do my job, and to be able to keep earning an income. But the issue of affordability of health care insurance is one of the most important things going on right now in our communities here in California. It allows people to hold a job, to earn a living and just to live their lives. The situation is not getting any better. I work as a nurse in San Quentin Prison now San Quentin Rehabilitation Center and the affordability of insurance for everybody, whether they are employed and actively working, whether they're looking for work or even if they're incarcerated, looking to get out and get themselves reestablished into the community, health care insurance is affecting all of us, from the richest to the poorest, from every aspect of society.
3/15/2024	Henry May Newhall Hospital	See Attachment #1.
3/15/2024	San Bernardino Mountains Community Hospital District	See Attachment #2.
3/19/2024	Jose Arciniega	I stand ready to collaborate with OHCA to achieve our shared goals of improved affordability and access to high-quality health care. Unfortunately, office staff's recommendation for California's first statewide spending target does not adequately consider the factors driving health care spending growth, and in doing so jeopardizes patient care. I am concerned that this unrealistic target will impact patient wait times which are already longer than

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		acceptable. It will penalize physicians who care for complex patients with disabilities and chronic diseases. The most vulnerable of patients might not be able to find physician practices or medical groups able to take them and meet targets. Running a practice or medical group is already a daunting challenge given overall inflation rates, staffing shortages which drive up labor cost, supply costs and the cost of operating and maintaining our clinics. Government reimbursement has not not kept pace with inflation leading to difficult financial losses for many practices. I am deeply concerned that the current proposal will have a disproportionate impact on our ability to maintain access and provide high-quality care. This target, which is based solely on the historical growth in household income, is overly narrow and fails to account for myriad factors that impact health care spending. To be credible, a target must not only consider but actually reflect these known factors: inflation; demographic factors, such as California's aging population; trends in labor and technology costs, such as the high costs of new pharmaceuticals and medical devices; and the overall cost of practicing medicine. In January, CMS projected the increase in the cost to practice medicine would be 4.6% in 2024 (Medicare Economic Index). The proposed target falls well below current lived experience. Physicians are a critical part of our state's health care system and I am concerned that those operating in the red will be penalized under this target. For Dignity Health Medical group, Inland Empire, meeting the proposed 3% target would mean reevaluating the services we provide, as well as care expansions and other investments we hope to make to improve our community's health and uncertainty over our ability to meet state mandates. On top of these challenges, OHCA staff's five-year target recommendation seeks to prematurely establish an enforceable spending target by proposing to do so before OHCA has: • Collected data to inform the establishment of a credible, attainable target • Promulgated rules around how these data would be analyzed • Laid out the rules for how entities would be held accountable for the targets Given these outstanding issues, we question the prudence of adopting a five-year target before data

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		become available and critical decisions have been made. Making health care more affordable requires thoughtful, long-term planning. Maintaining access to care and equity must be considered when looking to set these spending growth targets. For example, a comprehensive focus on health equity has the potential to lead to long-term cost savings but requires significant up-front investments and reorganization of delivery models. Unfortunately, this proposal would do the opposite — it would force cost-cutting measures at patients' expense. We ask the board to reject the OHCA staff proposal, and instead adopt a data-driven spending target that truly reflects the resources needed to provide life-saving care.
3/20/2024	Michelle Park	I stand ready to collaborate with OHCA to achieve our shared goals of improved affordability and access to high-quality health care. Unfortunately, office staff's recommendation for California's first statewide spending target does not adequately consider the factors driving health care spending growth, and in doing so jeopardizes patient care. I am concerned that this unrealistic target will impact patient wait times which are already longer than acceptable. It will penalize physicians who care for complex patients with disabilities and chronic diseases. The most vulnerable of patients might not be able to find physician practices or medical groups able to take them and meet targets. Running a practice or medical group is already a daunting challenge given overall inflation rates, staffing shortages which drive up labor cost, supply costs and the cost of operating and maintaining our clinics. Government reimbursement has not not kept pace with inflation leading to difficult financial losses for many practices. I am deeply concerned that the current proposal will have a disproportionate impact on our ability to maintain access and provide high-quality care. This target, which is based solely on the historical growth in household income, is overly narrow and fails to account for myriad factors that impact health care spending. To be credible, a target must not only consider but actually reflect these known factors: inflation; demographic factors, such as California's aging population; trends in labor and technology costs, such as the high costs of new

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3/21/2024	Brittany Bongga	I stand ready to collaborate with OHCA to achieve our shared goals of improved affordability and access to high-quality health care. Unfortunately, office staff's recommendation for California's first statewide spending target does not adequately

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3/22/2024	Nicole Key	I stand ready to collaborate with OHCA to achieve our shared goals of improved affordability and access to high-quality health care. Unfortunately, office staff's recommendation for California's first statewide spending target does not adequately consider the factors driving health care spending growth, and in doing so jeopardizes patient care. I am concerned that this unrealistic target will impact patient wait times which are already longer than acceptable. It will penalize physicians who care for complex patients with disabilities and chronic diseases. The most vulnerable of patients might not be able to find physician practices or medical groups able to take them and meet targets. Running a practice or medical group is already a daunting challenge given overall inflation rates, staffing shortages which drive up labor cost, supply costs and the cost of operating and maintaining our clinics. Government reimbursement has not not kept pace with inflation leading to difficult financial losses for many practices. I am deeply concerned that the current proposal will have a disproportionate impact on our ability to maintain access and provide high-quality care. This target, which is based solely on the historical growth in household income, is overly narrow and fails to account for myriad factors that impact health care spending. To be credible, a target must not

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3/22/2024	Pamela Davis	I stand ready to collaborate with OHCA to achieve our shared goals of improved affordability and access to high-quality health care. Unfortunately, office staff's recommendation for California's first statewide spending target does not adequately consider the factors driving health care spending growth, and in doing so jeopardizes patient care. I am concerned that this unrealistic target will impact patient wait times which are already longer than acceptable. It will penalize physicians who care for complex patients with disabilities and chronic diseases. The most vulnerable of patients might not be able to find physician practices or medical groups able to take them and meet targets. Running a practice or medical group is already a daunting challenge given overall inflation rates, staffing shortages which drive up labor cost, supply costs and the cost of operating and maintaining our clinics. Government reimbursement has not not kept pace with inflation leading to difficult financial losses for many practices. I am deeply concerned that the current proposal will have a disproportionate impact on our ability to maintain access and provide high-quality care. This target, which is based solely on the historical growth in household income, is overly narrow and fails to account for myriad factors that impact health care spending. To be credible, a target must not only consider but actually reflect these known factors: inflation; demographic factors, such as California's aging population; trends in labor and technology costs, such as the high costs of new pharmaceuticals and medical devices; and the overall cost of practicing medicine. In January, CMS projected the increase in the cost to practice medicine would be 4.6% in 2024 (Medicare Economic Index). The proposed target falls well below current lived experience. Physicians are a critical part of our state's health care system and I am concerned that those operating in the red will be penalized under this target. For Dignity Health Medical Group, meeting the proposed 3% target would mean reevaluating the services we provide, as well as care expansions and other investments we hope to make to improve our community's health and uncertainty over our ability to meet state mandates. On top of these challenges, OHCA staff's five-year target recommendation seeks to prematurely

Date	Name	Written Comment
		establish an enforceable spending target by proposing to do so before OHCA has: • Collected data to inform the establishment of a credible, attainable target • Promulgated rules around how these data would be analyzed • Laid out the rules for how entities would be held accountable for the targets Given these outstanding issues, we question the prudence of adopting a five-year target before data become available and critical decisions have been made. Making health care more affordable requires thoughtful, long-term planning. Maintaining access to care and equity must be considered when looking to set these spending growth targets. For example, a comprehensive focus on health equity has the potential to lead to long-term cost savings but requires significant up-front investments and reorganization of delivery models. Unfortunately, this proposal would do the opposite — it would force cost-cutting measures at patients' expense. We ask the board to reject the OHCA staff proposal, and instead adopt a data-driven spending target that truly reflects the resources needed to provide life-saving care.
3/22/2024	Health Access California	See Attachment #3.

Henry Mayo
Newhall Hospital

Type text here

March 15, 2024

Mark Ghaly, MD
Chair, Health Care Affordability Board
2020 West El Camino Avenue
Suite 1200
Sacramento CA 95833

Submitted via email to Megan Brubaker at: OHCA@hcai.ca.gov

Subject: Protect Access to Health Care, Reject 3% Cost Growth Target

Dear Dr. Ghaly:

We understand and share the goals of the Office of Health Care Affordability (OHCA) of improved affordability and access to high-quality health care. **Unfortunately, office staff's recommendation for California's first statewide spending target does not adequately consider the factors driving health care spending growth, and in doing so jeopardizes patient care.**

This target, which is based solely on the historical growth in household income, is overly narrow and fails to account for many factors that impact health care spending. To be credible, a target must not only consider but actually **reflect** these known factors: inflation; demographic factors, such as California's aging population; trends in labor and technology costs, such as the high costs of new pharmaceuticals and medical devices; policy changes that raise spending, like minimum wage and seismic mandates; high costs of hospital construction in California which include high costs and delays caused by state oversight, and the up-front investments hospitals make to improve the value of the care they provide, which — over the long term — reduce the cost of care.

For Henry Mayo, meeting the proposed 3% target would result in exacerbating the already significant uncertainty of our ability to meet unfunded state mandates (and still be able to stabilize and improve our financial performance coming out of COVID) like

the minimum wage law, seismic mandates, vendor diversity, water rationing plan, and minimum RN staffing ratios, among others

- Minimum wage law: We estimate that this law will increase our salary and benefit costs by nearly $10M through 2028 when the minimum wage increase will be fully phased in. This does not include expected wage compression within positions and pay ranges which, to ensure equity, will likely require increased wages to individuals who are currently making more than the proposed new minimum wage. This will further increase our costs.

- Seismic mandates: We recently completed the required NPC-4D and NPC-5, evaluation report at a cost of $663,000. We estimate that we will incur an additional cost of $3 million for consultants, structural engineers and architects to assist us to assign estimated costs and plan submittals to the state for infrastructure remediation identified in the report. We expect the ultimate cost of remediation to be several million dollars.

While our response to any state actions that would materially negatively impact our financial performance have not been formally developed, we expect that they may likely include, among other things:

- Re-evaluating the services we provide, as well as care expansions and other investments we hope to make to improve our community's health. For example, primary care practices, subacute, and behavioral health services.

- Considering ways to reduce current staff or hire fewer staff in the future, including offering fewer retention or recruitment bonuses.

On top of these challenges, OHCA staff's five-year target recommendation seeks to prematurely establish an enforceable spending target by proposing to do so before OHCA has:

- Collected data to inform the establishment of a credible, attainable target
- Promulgated rules around how these data would be analyzed
- Laid out the rules for how entities would be held accountable for the targets

Given these outstanding issues, we question the prudence of adopting a five-year target before data become available and critical decisions have been made.

Making health care more affordable requires thoughtful, long-term planning. For example, a comprehensive focus on health equity has the potential to lead to long-term cost savings but requires significant up-front investments and reorganization of delivery models. Ultimately, allowing for an opportunity to conceive and implement these improvements will allow the health care system to transform into one that California

patients need and deserve — a system that supports timely access to high-quality, person-centered care.

Unfortunately, this proposal would do the opposite — it would force cost-cutting measures at patients' expense. We ask the board to reject the OHCA staff proposal, and instead adopt a data-driven spending target that truly reflects the resources needed to provide life-saving care.

Sincerely,

Kevin Klockenga
President & CEO

MOUNTAINS
COMMUNITY HOSPITAL
The Heart of Mountain Healthcare

March 14, 2024

Mark Ghaly, MD
Chair, Health Care Affordability Board
2020 West El Camino Avenue
Suite 1200
Sacramento CA 95833

Submitted via email to Megan Brubaker at: OHCA@hcai.ca.gov

Subject: Protect Access to Health Care, Reject 3% Cost Growth Target

Dear Dr. Ghaly:

The Office of Health Care Affordability (OHCA) seeks to improve health care affordability and must do so without sacrificing access to or the quality of health care. We stand ready to collaborate with OHCA to achieve our shared goals of improved affordability and access to high-quality health care. **Unfortunately, office staff's recommendation for California's first statewide spending target does not adequately consider the factors driving health care spending growth, and in doing so jeopardizes patient care.**

This target, which is based solely on the historical growth in household income, is overly narrow and fails to account for myriad factors that impact health care spending. To be credible, a target must not only consider but actually **reflect** these known factors: inflation; demographic factors, such as California's aging population; trends in labor and technology costs, such as the high costs of new pharmaceuticals and medical devices; policy changes that raise spending, like minimum wage and seismic mandates; and the up-front investments hospitals make to improve the value of the care they provide, which — over the long term — reduce the cost of care.

For San Bernardino Mountains Community Hospital District, meeting the proposed 3% target would mean:

- Reevaluating the services we provide, as well as care expansions and other investments we hope to make to improve our community's health. We are planning to expand our Physical Therapy, Long-Term Care and surgical services to meet the needs of the community. We would not be able to move forward with these expansions under this proposed target.
- Considering ways to reduce current staff by outsourcing all non-patient care services. This would result in a tremendous layoff. We would also have to curtail the hiring of new staff including offering fewer retention or recruitment bonuses.
- Uncertainty over our ability to meet state mandates like minimum wage increases required under SB525 and costs of seismic retrofitting.

On top of these challenges, OHCA staff's five-year target recommendation seeks to prematurely establish an enforceable spending target by proposing to do so before OHCA has:

- Collected data to inform the establishment of a credible, attainable target
- Promulgated rules around how these data would be analyzed
- Laid out the rules for how entities would be held accountable for the targets

Given these outstanding issues, we question the prudence of adopting a five-year target before data become available and critical decisions have been made.

Making health care more affordable requires thoughtful, long-term planning. For example, a comprehensive focus on health equity has the potential to lead to long-term cost savings but requires significant up-front investments and reorganization of delivery models. Ultimately, allowing for an opportunity to conceive and implement these improvements will allow the health care system to transform into one that California patients need and deserve — a system that supports timely access to high-quality, person-centered care.

Unfortunately, this proposal would do the opposite — it would force cost-cutting measures at patients' expense. We ask the board to reject the OHCA staff proposal, and instead adopt a data-driven spending target that truly reflects the resources needed to provide life-saving care.

Sincerely,

Mark Turner, CEO

San Bernardino Mountains Community Hospital District

29101 Hospital Road ◆ P.O. Box 70 ◆ Lake Arrowhead ◆ California 92352 ◆ (909) 336-3651 ◆ www.MCHcares.com

HEALTH ACCESS CALIFORNIA

March 22, 2024

Mark Ghaly, M.D., Secretary of Health and Human Services
Chair, Health Care Affordability Board

Elizabeth Landsberg, Director
Department of Health Care Access and Information

Vishaal Pegany, Deputy Director
Office of Health Care Affordability,

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

Re: Comments by Others on Proposed Health Care Growth Cost Targets

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

Health Access California, the statewide health care consumer advocacy coalition committed to quality, affordable health care for all Californians offers comments on the comments provided by others on the proposed cost targets for 2025-2029.

We write to remind the board of the importance of the affordability of health care, and the rationale for the Office of Health Care Affordability. California consumers need a cost growth target that does not accept the status quo but is a goal to transform the system.

Consumers Pay for Health Care

Almost every dollar of health care spending is paid by consumers, directly or indirectly:

- Consumers as taxpayers pay for Medicare, Medi-Cal and the state and federal subsidies provided by Covered California.
- Consumers as working families pay indirectly in lost wages, literally hundreds of thousands of dollars over a working lifetime and as much as $10,000 a year when looking at both premiums and cost sharing.
- Consumers pay directly for a share of premium and out of pocket cost sharing including deductibles, copays, and coinsurance.
  Whether delivered through public programs or private coverage, almost every penny in the health care system comes out of the pocket of consumers.

The money paid to doctors, hospitals, drug manufacturers and health plans comes out of the pockets and paychecks of consumers.

1127 11th Street, Suite 925, Sacramento, CA 95814 | (916) 497-0923 health-access.org

What is the result of ever-escalating health care costs?

- Half of California consumers skip or delay care because of health care costs. They lack access today.
- The worker share of premiums has climbed by more than 8% per year.
- Employers have imposed deductibles on 80% of workers and hiked the amounts to a median of over $4,000 a year for family coverage.
- A family making a median family income of $85,000 can spend more than $10,000 annually on family share of premium and the median deductible.
- And that's on top of losing as much as $10,000 in lost wages paid for the employer share of coverage.
- Is it any wonder that medical debt is so common? Or that bankruptcy related to illness and disability is commonplace?
- And it is worse for lower income families. And worse yet for communities of color.
- And worse yet for those who need care the most and who must pay the most to get care.
- Quality of care depends on being able to afford to go to the doctor, get the needed test, and pick up the prescription. Lack of affordability damages that.

The Reason for the Office of Health Care Affordability

The reason the Governor proposed, and the Legislature enacted the law governing the Office of Health Care Affordability was out of a recognition that the current approach is not sustainable for California families, as consumers, or for the purchasers such as employers and union trust funds that pay for care.

The fundamental charge of the Board and the Office is to turn the ship of the health care system toward the triple aim of lower costs, better outcomes, and improved equity.

A Choice for the Board:
Base the Target on the Cost of Doing Health Care Business as Usual
Or Base the Target on What Consumers Can Afford

Most physician organizations and hospital representatives protest, at length, that the target must be based on the cost of doing business as usual. They offer a litany of reasons for sustaining the current unsustainable cost growth trend:

- Partially double-counting factors such as aging and inflation.
- Pointing to prescription drugs as cost drivers while ignoring both price drops and prescription drug costs as revenue centers for hospitals and physicians.
- Acting as if revenue is the only thing that matters in a budget, not control of their own operating costs as do most businesses.
- Pointing to Medicare indices, while rejecting payment based on a percentage of Medicare when proposed for private purchasers.
- Not accounting for costs built into the base of spending by 2025.

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Hospital representatives offer a litany pages-long of the reasons why business as usual in terms of health care costs is the choice that the Board should make.

In contrast, a majority of the commenters, representing consumers, labor, and purchasers, ask that the Board base the cost target on an indicator of the ability of consumers to afford care and coverage, median household income with a twenty-year lookback from 2003 to 2022 or lower than 3% if possible.

Many of these consumer commenters offered personal experiences of unaffordable health care, spending $1,000 or $2,000 a month for coverage, another being $3,000 out of pocket for an emergency room visit even though they had coverage, and several spending hundreds of thousands of dollars on care. These stories were heart-wrenching and life-altering.

At the Advisory Committee meeting, several providers spoke about high deductible coverage and the consequences of it but failed to acknowledge that the wider prevalence of high deductible coverage is a direct response to high health care costs, as employers and other purchasers try to provide coverage at a premium the purchaser can afford but with damage to consumers who then go without needed care because of lack of affordability.

One purchaser, a labor-management trust, detailed that their members had foregone $200,000 in wages over the last twenty years or $10,000 a year—for hotel housekeepers and cooks trying to live on $30,000 or $40,000 a year in San Francisco. What a difference $10,000 a year would have made for those families. The same purchaser said that they and other labor-management trust funds at looked the growth in claims for Kaiser coverage in recent years and found that those claims costs had grown 2.4% per year, far lower than the premiums, for reasons that are utterly unclear.

Commenters on the spending target proposal representing health plans supported basing the target on consumer affordability as measured by the most recent ten years of median household income. We wonder whether these commenters would also support that approach in years in which that approach yielded 1% instead of 4.2%? Several of these commenters suggested the possibility of a "glide path" without offering details of what is envisioned.

Summary
In adopting a cost growth target, the formal comments to date present a choice for California:

- Begin moving toward a transformed system in which health care cost growth is based on what consumers, the ultimate payers of all health care costs, can afford with an emphasis on improved outcomes and greater health equity. For us as consumer advocates, the choice is clear: we pay the bills, we can't afford this. We cannot let the lack of affordability get even worse. That's why we fought to create the Office of Health Care Affordability. That is why we have been at every meeting and done our best to lay out our case for consumers.

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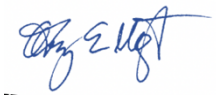
- Or base the cost target on the present, unsustainable cost growth that is denying half of California consumers access to care due to lack of affordability, impeding quality of care, and worsening inequity due to income and generational wealth and for persons of color and persons with significant health needs.

We stand ready to work with those who are willing to work toward a transformed system. We oppose business as usual.

Sincerely,



Beth Capell, Ph.D.
Policy Consultant

Anthony Wright
Executive Director

cc: Members of the Health Care Affordability Board
Assemblymember Robert Rivas, Speaker of the Assembly
Senator Mike McGuire, Senate President Pro Tempore
Assemblymember Mia Bonta, Assembly Health Committee Chair
Senator Richard Roth, Senate Health Committee Chair
Assemblymember Akilah Weber, M.D., Budget Subcommittee on Health Chair
Senator Caroline Menjivar, Senate Budget Subcommittee on Health and Human Services Chair
Richard Figueroa, Assistant Cabinet Secretary, Governor's Office
Mary Watanabe, Director, Department of Managed Health Care

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