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Health Care Affordability Board
January 24, 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
01/29/2024	Parker Duncan	"Wanted to add in a couple documents that inform the importance of OHCA's using its mandates and power to direct our HC dollar tracking - and ultimately spend - towards efficiency, which is mostly primary care focus. First is the 'big read' - NASEM's 2021 update on Rebuilding PC in the US; as well as a 'call to arms' piece from Dr. Grumbach [on one of your advisory panels] about transitioning to Primary Care for All. Links and copy of both attached. nationalacademies.org - annfammed.org Happy to discuss any of these further."
02/16/2024	Cher Gonzalez on behalf of the American Diabetes Association	See Attachment #1. "My client, the American Diabetes Association, ("ADA") is pleased to submit the attached letter regarding cost-reducing strategies for your consideration, as requested of stakeholders at the January 2024 Health Care Affordability Board Meeting. Diabetes mellitus is a common and costly chronic disease which impacts over 3 million[i] Californians, more than 10% of the state's population. According to the Centers for Disease

		Control in 2022, the total cost of care for people with diagnosed diabetes was $413 billion and medical costs associated with diabetes were about $12,000 per person.[ii] Further, in 2022 the ADA published the Economic Costs of Diabetes in the U.S which found that people with diagnosed diabetes now account for one of every four health care dollars spent in the U.S.[iii] Policy makers can do more to reduce the incidence of Type 2 diabetes and improve the health of Californians living with diabetes. The ADA firmly believes that by engaging in evidence-based strategies that focus on improving health outcomes for people living with diabetes, cost savings will be achieved. We, therefore, offer strategies for your consideration. We would love the opportunity to meet with you or appropriate staff regarding the suggestions." [i] http://main.diabetes.org/dorg/docs/state-fact-sheets/ADV_2020_State_Fact_sheets_CA.pdf [ii] By the Numbers: Diabetes in America | Diabetes | CDC [iii] $412.9 Billion in Health Care Dollars |ADA (diabetes.org)
02/23/2024	Ben Johnson on behalf of California Hospital Association	See Attachment #2.
02/23/2024	Beth Capell on behalf of Health Access	See Attachment #3.

Attachment #1

February 16, 2024

Ms. Elizabeth Landsberg, Director
Office of Health Care Affordability
California Department of Health Care Access and Innovation

Submitted electronically to: ohca@hcai.ca.gov

Dear Director Landsberg,

The American Diabetes Association (ADA) is pleased to submit the following examples of cost-reducing strategies for your consideration, as requested of stakeholders at the January 2024 Health Care Affordability Board Meeting.

Diabetes mellitus is a common and costly chronic disease which impacts over 3 million[i] Californians, more than 10% of the state's population. According to the Centers for Disease Control in 2022, the total cost of care for people with diagnosed diabetes was $413 billion and medical costs associated with diabetes were about $12,000 per person.[ii] Further, in 2022 the ADA published the Economic Costs of Diabetes in the U.S which found that people with diagnosed diabetes now account for one of every four health care dollars spent in the U.S.[iii]

Policy makers can do more to reduce the incidence of Type 2 diabetes and improve the health of Californians living with diabetes. The ADA firmly believes that by engaging in evidence-based strategies that focus on improving health outcomes for people living with diabetes, cost savings will be achieved. We, therefore, offer the following suggested strategies for your consideration.

Cost-Savings Strategy: Encouraging Diabetes Prevention Program Coverage by Private Insurers

It is estimated that one in three US adults has prediabetes, and in California specifically, about 46% of adults are estimated to have prediabetes or undiagnosed type 2 diabetes.[iv] Prediabetes is a serious health condition where blood sugar levels are higher than normal, but not high enough for a diabetes diagnosis. Without intervention, people

with prediabetes are at high risk of developing type 2 diabetes within five years, which puts them at risk of serious health problems, including heart attack, stroke, blindness, kidney failure and amputation.

To combat the rising incidence of prediabetes and Type 2 diabetes in the United States, the National Diabetes Prevention Program (DPP) was created by the Centers for Disease Control (CDC) in 2010. The DPP helps people who are at risk prevent or delay type 2 diabetes, which lowers their risk of other serious health problems, such as heart disease and stroke. The DPP follows a twelve-month evidence-based curriculum where participants learn skills and receive group support. Those who lose five to seven percent of their body weight and add one hundred and fifty minutes of exercise per week can reduce their risk of type 2 diabetes by up to fifty eight percent.

The DPP is delivered both in person and online, and costs about $500 per participant and is covered by Medicare and many private insurers, but not all. And, according to the CDC, “providing coverage for the program matters. In addition to making the program more accessible and affordable for employees or members, one study found that lifestyle change program participants who received coverage for the program through their health insurance plan achieved slightly better outcomes in attendance and average weight loss than did those who paid out of pocket or through a grant.”[v]

Studies have shown that participation in the DPP results in significant short-term health care cost savings. For example, one study showed that at year one the DPP population had a reduction in health care spend of $1169 per participant with cost savings driven by fewer hospital admissions and shorter length of stay.[vi] By encouraging health plans, insurers, and employers to offer the National DPP as a covered benefit, the Office of Health Care Affordability will be encouraging improved health outcomes for Californians while helping to reduce health care expenditures

Cost-Savings Strategy: Encouraging Insurers to Cap Out of Pocket Costs on Insulin, and Requiring Any Health Care Entity that Purchases CalRx Insulin to Pass Those Savings on to California Consumers

Insulin is used to treat all types of diabetes: type 1 diabetes, type 2 diabetes, and in some cases, gestational diabetes. The timely, consistent, and appropriate use of insulin is necessary to prevent both short- and long-term diabetes complications, including diabetic ketoacidosis (DKA), coma, chronic kidney disease (CKD), retinopathy and vision loss, heart disease and stroke, lower-limb amputations, and even premature death. However, for too many Californians, insulin has become too expensive, and cost alone is sometimes the number one barrier to adequate use and medication adherence.

Based on Milliman's 2021 Consolidated Health Cost Guidelines Sources Database (CHSD) claims data, the average cost of insulin per prescription per month is $521.

When the cost of insulin is high, people stop taking it. According to the California Health Benefits Review Program (CHBRP)[vii], utilization of filling one's insulin prescription decreases by eight percent when cost sharing doubles. However, a patient's insulin needs stay steady. Limiting allowed cost sharing (copayments, coinsurance, and deductibles) for insulin to $35 for a 30-day supply can increase medication adherence and help prevent both acute and long-term diabetes complications. Once copayments of medications like insulin are capped, utilization increases, with estimates of a 6.6% increase in utilization of insulin post mandate for those enrollees subject to an insulin cost cap.

Estimates show that at baseline there are 123,442 enrollees who use insulin in commercial and CalPERS DMHC-regulated plans and CDI-regulated policies, where 68,344 enrollees using insulin have cost sharing that does not exceed the $35 cost-sharing cap (55%). CHBRP estimates 55,098 enrollees (45%) using insulin have cost sharing that exceeds the $35 cap.

To date, twenty-five states have limited cost-sharing for insulin on state-regulated health plans, in addition to Medicare[viii] and state Medicaid programs, to great success. Additionally, US insulin manufacturers have noted the benefits of limiting cost-sharing for their products and have recently voluntarily lowered the list prices[ix] on many of their insulin products. However, these changes are not in statute and can be revoked at any time.

And while we applaud the efforts by CalRx to offer $30 insulin to California in the future, we are concerned that if health plans do not cap the cost sharing for insulin at $30- $35, then Californians will be forced to purchase insulin from CalRx outside of their insurance, which means these purchases will not count towards their out-of-pocket maximum. This will create an unfair burden on people living with diabetes and essentially allow insurers and health plans to avoid covering insulin, which is required by California Health and Safety Code Section 1367.51. Further, if health care entities such as hospitals, or closed system health plans like Kaiser, purchase insulin from CalRx, we urge CalRx and the Office of Health Care Affordability to require these entities pass these savings on to patients by capping insulin copays at $35.

Limiting cost-sharing on insulin may result in improved blood sugar control, a reduction in healthcare utilization such as emergency department (ED) visits, a reduction in long-term diabetes complications, and improved quality of life for patients. Lowering the cost-sharing for insulin can improve health disparities, especially for ethnic and racial groups

and people of lower socio-economic status. We therefore urge the Office of Health Care Affordability and CalRx to encourage health plans and insurers to cap insulin cost sharing at $35, to avoid Californians having to go outside of their healthcare coverage to purchase insulin, and requiring any healthcare entity that purchases insulin from CalRx to pass these savings on to consumers.

The ADA applauds efforts which focus on encouraging health insurers to engage in evidence-based practices to improve health outcomes, which will lower health care costs for all. Should you have any questions please feel free to reach out to me at _______.

Sincerely,

Christine Fallabel

Director, State Government Affairs and Advocacy
The American Diabetes Association

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[i] http://main.diabetes.org/dorg/docs/state-fact-sheets/ADV_2020_State_Fact_sheets_CA.pdf
[ii] By the Numbers: Diabetes in America | Diabetes | CDC
[iii] $412.9 Billion in Health Care Dollars |ADA (diabetes.org)
[iv] Diabetes Facts and Risk Factors | LA County Department of Public Health - Diabetes Prevention
[v] Offering a Lifestyle Change Program as a Covered Benefit | National Diabetes Prevention Program | Diabetes | CDC
[vi] Cost Savings and Reduced Health Care Utilization Associated with Participation in a Digital Diabetes Prevention Program in an Adult Workforce Population - PMC (nih.gov)
[vii] SB 90 Insulin Affordability_Key Findings_0.pdf (chbrp.org)
[viii] https://www.medicare.gov/coverage/insulin
[ix] How the Inflation Reduction Act Is Lowering Insulin Prices - GoodRx

February 22, 2024

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

Subject: **Comments on the January 2024 Health Care Affordability Board and Advisory Committee Meetings**
(Submitted via Email to Megan Brubaker)

Dear Dr. Ghaly:

California's hospitals and health systems share the Office of Health Care Affordability's (OHCA) goals of making health care more affordable while preserving and improving access to high-quality, equitable care and seek to partner with OHCA in pursuit of these worthwhile objectives. In service of these goals, the California Hospital Association recommends the following:

Reconsider OHCA's Spending Target Proposal

OHCA has an obligation to improve the affordability of health care **without sacrificing access to or the quality of health care**. While the office has shown clear commitment to improving affordability, its final recommendation for California's first statewide spending target misses the mark when it comes to preserving access, equity, and quality. *CHA urges the OHCA board to reconsider OHCA staff's proposed 3% target for 2025-29*, which would represent a sudden 40% drop in health care spending growth relative to long-term historical trends. The proposal:

- Fails to strike achieve the multiple objectives in state law related to the targets
- Ignores the drivers of health care spending, such as inflation and California's aging population
- Sets California apart as an outlier from other states, which have often failed to meet their higher spending targets
- Unnecessarily rushes toward the finalization of not only the initial, non-enforceable spending target, but also enforceable targets for 2026 and beyond

Take Time to Make a Thoughtful Decision. Setting a spending target is the most impactful decision the OHCA board will make. It will not only shape the growth trajectory of a $500 billion economic sector in California, but also affect Californians' ability to access cutting-edge, patient-centered, and life-saving care. When the legislation establishing OHCA was developed, lawmakers recognized this important responsibility and sought to develop a process that supported it in two ways:

- First, state law requires the board to balance multiple considerations: affordability, access, quality, equity, and workforce stability. To date, attention has focused almost exclusively on the first

consideration, leaving major gaps that must be addressed if the board is to meet its statutory mandate.

- Second, state law establishes rolling deadlines: June 2024 for the board to set an initial, non-enforceable target for 2025, June 2025 for the first enforceable target for 2026, and so on. This timeline allows for thoughtful deliberation and the drawing of lessons from the initial year's data collection. By proposing a multi-year target at this stage, OHCA is missing a critical opportunity to ensure the target is realistic, achievable, and supportive of hospitals and other providers' efforts to improve the value of the care they provide.

Accordingly, the board should take the time needed to reach a thoughtful decision on the spending target, including taking seriously the feedback OHCA receives from regulated entities through the public comment process. *The board should consider using the March board meeting to deliberate this feedback, and return at a later date, within the time afforded in statute, to make this consequential decision.*

Obtain Meaningful Feedback from the Advisory Committee. Obtaining and taking time to consider the feedback of the health care field is all the more essential given deficiencies in how advisory committee input has been transmitted to the board to date. At the most recent advisory committee meeting, nearly six hours of discussion was boiled down to a verbal summary to the board lasting less than five minutes. Moreover, the summary papered over genuine disagreements and questions around OHCA's proposed spending target, creating a mistaken impression of near consensus. This raises process concerns which can and must be addressed through greater consideration of the diverse perspectives being aired on matters before the advisory committee.

Recognize the Drivers of Health Care Spending. OHCA's proposed target ignores the drivers of health care spending, instead focusing exclusively on a single economic indicator that bears little relation to the health care sector. Without changes that account for the true drivers, the spending target risks forcing health care providers to cut back on the care they provide, or face penalties for delivering the care their patients need. To avoid this, OHCA must recognize at least the following six essential components in setting a spending target:

- **Inflation.** Over the next five years, the Legislative Analyst's Office projects inflation to be 3.4% annually. In other words, OHCA's proposed spending target would dictate a decline in real health care spending of nearly a half a percentage point each year, assuming no change in utilization patterns 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 unable to compete with other states and sectors for workers.
- **Growing Health Needs of an Aging Population.** The oldest members of the baby boomer generation are entering their late 80s and 90s, while the youngest members are just now reaching retirement age. Health care costs for seniors are five to nine times those for children and youth. Under these demographic trends, 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 a factor unaccounted for in OHCA's proposed spending target.
- **Technological Change.** In health care, technological development often comes in the form of new and expensive drug therapies and medical devices. Recent examples include Sovaldi, a hepatitis C drug that debuted at a price of $84,000 per treatment, and Ozempic, a popular diabetes and weight loss drug that costs over $10,000 per year and is intended for use over a patient's lifetime. Further novel therapies, like a new gene therapy for sickle cell amenia that will

cost up to $3 million, are on their way. OHCA does not regulate pharmaceutical manufacturers, intermediaries, and retailers. However, payers and providers are responsible under the target for any growth in these unregulated sectors. To recognize this contradiction, OHCA must recognize the cost of pharmaceutical and other innovation in the spending target to avoid punishing health care entities for factors beyond their control and protect against the rationing of new, life-saving treatments.

- **Labor Intensity.** Health care is a labor-intensive sector. For hospitals, labor expenses make up nearly 60% of total costs. Sectors that are labor intensive tend to grow relatively more expensive over time, commanding a greater share of people's incomes, as they do not benefit as much from cost-saving automation seen in other industries, like manufacturing which, unlike health care, is more subject to national and international competition. Broad economic indicators like median family income and inflation average out these fundamental differences between industries, making them ill-suited as a reference point for a health care spending target, unless adjustments are made. Consistent with findings from the Centers for Medicare and Medicaid Services' Office of the Actuary, OHCA should recognize this important factor in setting the 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 new health care worker minimum wage — will add billions of dollars in health care spending. In fact, these two recent policy changes, on their own, will raise health care spending by 2.5% in tandem over the next three years. The proposed spending target does not accommodate these or any other changes enacted by policymakers.
- **Facilitation of Thoughtful, Meaningful Change.** To make care more affordable without harming access, quality, or equity, health care entities will need to make new investments and change their 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, multi-year 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 would bear the brunt, 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.

Other States Have Struggled to Meet Their Targets. Spending target programs have been implemented in eight other states — and more often than not, states have missed their targets. As the figure below shows, other states have missed their targets in 10 out of a possible 17 years, or six out of a possible nine years when only considering the pre-COVID-19 period. On average, other states have missed their targets by 1 percentage point, showing they set their targets 20%-25% lower than they reasonably should have.

Other States Have Missed Their Spending Targets More Often Than Not								
	All Years				Pre-COVID-19			
	Average Performance	Average Target	Years Target Missed	Years in Place	Average Performance	Average Target	Years Target Missed	Years in Place
Connecticut	6.1%	3.1%	1	1			0	0
Delaware	5.3%	3.3%	2	3	5.8%	3.8%	1	1
Massachusetts	3.5%	3.4%	5	9	3.6%	3.5%	4	7
Nevada		2.8%	0	0			0	0
New Jersey		3.1%	0	0			0	0
Oregon	3.5%	3.3%	1	1			0	0
Rhode Island	1.5%	3.3%	1	3	4.1%	3.2%	1	1
Washington		3.8%	0	0			0	0
Averages/Totals	**4.0%**	**3.0%**	**10**	**17**	**4.5%**	**3.5%**	**6**	**9**

Nevertheless, OHCA Has Proposed a Target Even Lower Than Other States. California's proposed target is lower than that of 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% — a factor entirely unrecognized in OHCA's proposal.

Importantly, other states' targets are higher than OHCA's proposal because all other states phase their targets in, typically over four to five years. Rhode Island, which had a flat 3.2% target in place for four years, had been the lone exception. However, the state subsequently revised its approach and set its target at 6% in 2023, 5.1% in 2024, then incrementally lowering it thereafter to 3.3%.

OHCA's aberrantly low proposed target would mean that even health care entities making strides toward improving affordability would miss the spending target in at least one of the next five years, exposing them to the largely undefined yet potent enforcement tools at the office's disposal.

Strive for a Transparent and Standardized Data Collection Process

While CHA has been supportive of OHCA's overall approach to data collection, the revised regulations fail to make improvements to ensure transparency, standardization, and clarity, including for how a quarter of the state's health care spending, that under Medi-Cal, will be treated.

- **Lack of Transparency.** Inaccurate or manipulated data will threaten the credibility of the spending target program. It is troubling that neither providers nor the office itself will have line of sight into the spending that payers attribute to providers due to there being no validation process. Such processes exist as part of other health care financing programs — like the Maryland All-Payer Model and the California Hospital Quality Assurance Fee Program — and must be included in OHCA's data collection process.
- **No Standardization.** OHCA's data collection rules lack clear and consistent standards for how health plans and insurers must attribute their members to providers when assignment is not clearly determined by contractual arrangement. Rather, the only requirement is that payers use a "[payer]-developed, rules-based approach." This is concerning as it will:
    - Increase the incidence of misattributing patients to providers
    - Result in the attribution of patients to providers that do not meaningfully influence a patient's utilization patterns and costs
    - Create apples-to-oranges comparisons of spending across payers and providers

  - Opens the door for data to be used in ways OHCA didn't intend

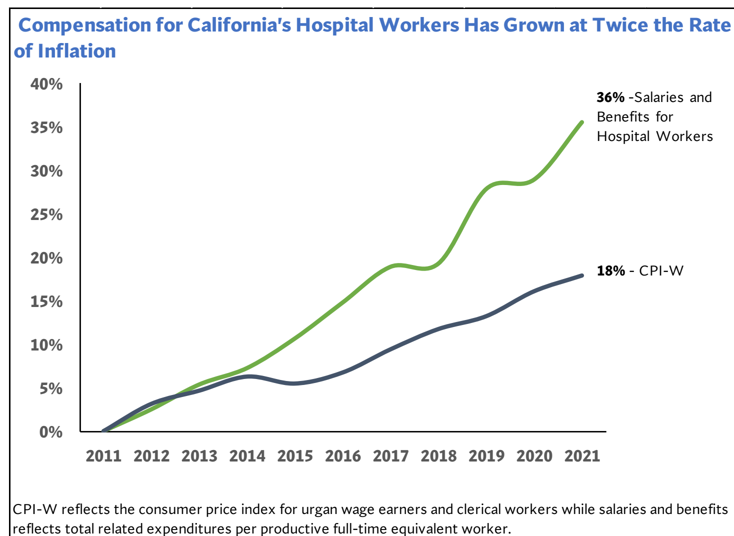
  While the next couple of years can and should be used to learn about which approaches to patient attribution do and do not work in California, reasonable guardrails should be established now to ensure the collection of credible and consistent data.
- **Clarity on Medi-Cal Spending.** Medi-Cal financing is enormously complex, so getting the data collection and analysis pieces right will take time. Apart from establishing that the Department of Health Care Services (DHCS), in lieu of the health plans, will initially provide the Medi-Cal spending data, the proposed guidance largely sidesteps related issues. We look forward to working with OHCA and DHCS to stand up an effective Medi-Cal data collection process.

Reconsider Hospital Spending Methodology

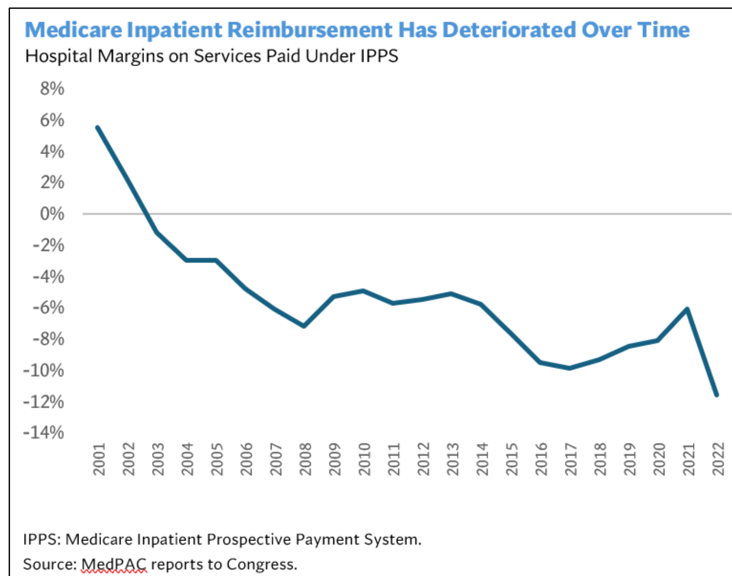
In January, OHCA introduced a new effort to assess hospital spending, citing hospital costs and prices as a driver of the lack of affordability. This focus on hospital spending unfairly targets a single provider type, despite health care being a vast network, of which hospitals are one piece. Moreover, it comes at a time of unprecedented financial distress, with 52% of hospitals experiencing negative operating margins according to data collected and analyzed by OHCA's parent department. This misplaced focus occurs as health insurance companies — four of which effectively control the entire commercial market in California — are earning billions and engaging in practices that undermine access to patient-centered care.

What's more, the information presented by OHCA on hospital spending misled more often than it clarified. Factors this presentation ignored include:

- **Hospitals Provide Services, Not Goods.** The inflation rates displayed in the chart from the American Enterprise show a clear pattern — service sectors like health care, education, and child care have experienced high inflation, while goods like clothing, cars, toys, and TVs have seen low inflation. The drivers of these differences are as previously discussed: the former are labor intensive industries not subject to labor-saving technological change or significant international competition; the latter are not.
- **Advancements in Health Care Often Skew Measures of Inflation** Measurements of inflation frequently struggle to appropriately reflect changes in the quality of goods and services over time, a challenge that is only more true in health care. Research by David Cutler and the Bureau of Economic Analysis reveals that the failure to appropriately reflect quality improvements in health care leads to a vastly overstated picture of medical inflation. **In fact, when properly accounted for, medical inflation shifts from being a half percentage point above economy-wide inflation to over a percentage point below.** A similar phenomenon applies specifically to hospital services, which the Bureau of Labor Statistics has found to be overstated by roughly a quarter of a percentage point. Incorporating this adjustment reduces aggregate price inflation for hospitals services to be roughly in line with that of educational services and motor fuels over the last 23 years.
- **Hospital Labor Expenses Outpace Inflation.** Hospital prices are growing because hospital expenses are growing. For example, labor expenses for hospitals grow in excess of 5% in a typical year — significantly higher than inflation. Over 90% of this growth is for non-supervisory workers and the majority is due to higher wages. The figure below shows that hospital worker compensation has been twice that of broader inflation.



- **California Hospital Prices Are No Higher Than Differences in Cost of Living and Labor Expenses Would Indicate.** The OHCA slides show commercial prices for hospital inpatient and outpatient services to be higher than average national prices by 8% and 40% respectively. The presentation neglected to provide important context for why California hospital prices may differ from those in other states — namely, that compensation for nurses, hospitals' largest group of workers, is 33% higher than the national average *after* accounting for the fact that California's cost of living is nearly 13% higher than for U.S. residents as a whole.
- **Commercial Reimbursement Covers Public Payer Shortfalls.** OHCA's presentation shows that reimbursement levels are higher for commercial coverage than Medicare. On its face, this can lead to a false understanding that commercial reimbursement levels are excessive. In reality, commercial payers play a pivotal role in covering growing shortfalls in reimbursement from public payers. As the figure below shows, inpatient reimbursement in Medicare now covers just 88 cents for every dollar spent on patient care. This shortfall is only increasing, compounded by a growing shift from commercial to government coverage under Medicare and Medi-Cal.



- **Over Half of Hospitals Are Operating in the Red.** Fifty-two percent of California's hospitals had negative operating margins in 2022, according to HCAI data, meaning the prices they are charging are insufficient to cover their expenses.

Request Close Consultation with the Hospital Field. As this effort to measure hospital spending moves forward, OHCA must lean heavily on experts with current, real-world experience in hospital finance. Otherwise, OHCA risks developing a methodology that fails to appropriately capture the full realities and complexities of how hospitals fund the care they provide to California's patients.

Conclusion

Plan for 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. A poorly considered, hastily developed spending growth target would have dire consequences for millions. CHA is committed to helping the office develop a thoughtful, data-driven approach. We are grateful for the opportunity to comment, and look forward to continuing to work closely with OHCA staff and its board to craft policies that meaningfully address affordability challenges while protecting access to health care.

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
Donald B. Moulds, Ph.D.
Dr. Richard Pan

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Executive Director

Organizations listed for identification purposes

February 23, 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: Office of Health Care Affordability Proposed Spending Target

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, supports the proposed spending target of 3% over the five years from 2026 to 2029 as well as the proposed methodology which relies on median household income rather than the wealth of the economy.

Consumers' Ability to Afford Care, Not the Wealth of the Economy

Health Access California supports the target methodology proposed by the Office of Health Care Affordability and the target proposed by the Office of Health Care Affordability staff. The Board has discussed at length basing the critical importance of basing the spending growth targets on median household income which reflects the ability of consumers to afford both health care and coverage rather than the wealth of the California economy as reflected in measures such gross domestic product (GDP).

Median household income better reflects the lived experiences of Californians. A cost growth target grounded in household income is also a better test of whether Californians' health costs, in premiums, cost-sharing, and other costs, are becoming more unaffordable. Given the extreme wealth inequality in California, and the structure of our economy, economic measures such as gross domestic product—which includes how well movie studios do and how many iPhones sold—is not suited for this purpose of evaluating consumer affordability.

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

If California had a system of financing health care that was based on the wealth of the economy such as a single payer system based on progressive taxation of wealth and income, basing the growth of health care costs on the wealth of the California economy would make sense to us. California does not. Instead, about half of all Californians rely on employer-based coverage which is regressively financed through lost wages, lost wages that are spent on health benefits instead of take-home pay. So long as Californians rely on regressive financing of employer coverage, consumer affordability must drive the discussion rather than the wealth of the economy.

Consumer affordability is at the core of our perspective.

- In California today, those who can afford health care the least pay the most as a proportion of their income.
- Those who need care the most, such as those with MS, HIV/AIDS or a serious disability, also pay the most in terms of out-of-pocket costs.
- Consumer spending on health care comes in the form of worker share of premium and deductibles and other out of pocket costs that are both proliferating and escalating as well as lost wages spent on the employer share of health benefits.

What is the result? A health care system in which today Californians lack access, inequity abounds, and quality suffers, all because of lack of affordability. The Board has heard from a broad range of Californians facing a crisis of affordability: teachers, hotel workers, people with MS, small business owners and more.

Lack of Affordability Means Lack of Access Today

Californians with job-based health coverage often cannot afford the care they need. Because of high health care costs, Californians lack access today:

- Over half of Californians (53%) skip or delay doctor visits or prescriptions because of costs[1].
  - About half of these Californians got worse because they did not get the care they needed.
- Family coverage costs $24,000 with almost $10,600 coming directly out of a family's pocket, including both family share of premium and median deductible[2],
  - $10,600 for health care paid out of $85,300 median family income. How does anyone afford that while still paying for other needs?
  - Family coverage is 12.2% of median income for share of premium and median deductible for a family with a median income of $85,300.
  - And even more in lost wages for the employer share of coverage.
- Deductibles have proliferated and gotten worse[3]:

[1] The 2024 CHCF Health Policy Survey, CHCF, Jan 2024
[2] https://laborcenter.berkeley.edu/measuring-consumer-affordability/ January 2024
[3] https://laborcenter.berkeley.edu/measuring-consumer-affordability/ January 2024

  - In 2002, only 1 in 3 Californians with employer coverage had a deductible.
  - In 2022, almost 8 in 10 (77%) do—and some deductibles are over $7,000.
- Lost wages due to health care costs amount to $125,000 nationally over the last 33 years[4].

People don't get care today because they can't afford to go to the doctor, pick up their prescriptions or get other necessary care. High health care costs deny Californians access to care today.

Today's Lack of Affordability Makes Inequity Worse

- High health care costs are worse for Black, Latino/x and Multiracial Families[5]
  - Black, Latino/x and multiracial Californians are more likely to be worried about being able to afford health care, including out of pocket costs and premiums.
  - Black (53%), Latino/x and multiracial Californians (46%) are more likely to report difficulty paying medical bills as well as medical debt.
  - Health premiums are almost 20% of income for Black and Latino/x workers[6]. And deductibles are on top of that.
- The wage penalty is also greater for workers of color as a proportion of income:
  - By 2019, health care premiums were almost 20% of earnings for Asian, Black and Hispanic families while they were only 13.8% for White families.[7]

Quality Depends on Access to Care

Good health outcomes depend on regular access to care—and high health care costs stand in the way of regular care because consumers fail to go to the doctor, take their prescriptions, get necessary tests or follow up care, all because of lack of affordability.

- Twelve of the 13 equity and quality measures adopted by DMHC for use across all lines of business, including both Medi-Cal and commercial coverage, depend on going to the doctor and taking your prescriptions[8].
  - Childhood immunizations, diabetes control, high blood pressure, asthma, depression screening: these measures and more depend on consumers being able to afford doctor visits and their medications.
- The same is true for most of the measures adopted by DHCS for Medi-Cal managed care.

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[4] Employer Health Coverage and Its Association with Earnings Inequality, Hager et al, Jan. 25, 2024,
[5] CHCF Policy Survey, CHCF, Jan 2024
[6] Employer Health Coverage and Its Association with Earnings Inequality, Hager et al, Jan. 25, 2024,

[7]Employer Health Coverage and Its Association with Earnings Inequality, Hager et al, Jan. 25, 2024

[8]DMHC Equity and Quality Measures, 2022: and Health Equity And Quality Committee, 2022

- Even measures associated with hospitalization or emergency room use are associated with lack of affordability:
    - People end up in the emergency room with ambulatory sensitive conditions because they could not afford the doctor's visit, the medications or other follow-up care.
    - People bounce back into the hospital through a readmission because of the lack of access to adequate supports post-hospitalization, much of which is related to income, ability to pay for care and generosity of benefits.

Without regular care, patients get worse and end up in the ER sicker: it is a vicious cycle caused by lack of affordability.

California Should Lead, not Lag, Targets in Other States

Other states with cost commissions have targets for 2024-2027 in the range of 2.8%-3.3%, putting the staff recommendation of 3.0% squarely in the same range as other states. A target of 3.5% or 4% would be far higher than the targets in other states[9].

One commenter, largely relying on a report published in 2022 which relied on data from as early as 2012, pointed to a somewhat higher average target of 3.3% while pointing to California's GDP (or gross state product) in 2024[10]. This commenter ignores the fact that targets in the other states for the years after 2022 are consistently lower.

After years of conversations and now implementation of this new Office of Health Care Affordability, Californians should not have to settle for a target that is less ambitious than what Washington, Oregon, Massachusetts, and other states around the country are using for a goal in the next several years.

Inflation

The same commenter who relies on an outdated report selectively picks inflation projections, relying on a Legislative Analyst Office estimate from last fall which is higher than those of the California Department of Finance or the Congressional Budget Office---or the observations of the Federal Reserve.

In a more general sense, the round of inflation that occurred post-pandemic is abating, and that inflation will be built into the base of spending for the 2025 target and the years beyond. Inflation is generally on a downward trend, not upward. The 2025 target will be reported in 2027. By then, the inflation of 2022 and 2023 will be years in the rearview mirror. If there is a reversal of trend, the Board has the flexibility to review the target then.

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[9] Slide 132:

[10] December OHCA Written Public Comment, December 2023.

Workforce Impacts: Observations, Experience of Massachusetts

Some have asserted that there will be a lack of access to care because slower health care cost growth will result in a smaller health care workforce.

First, we note that the cost *growth* target is not a cut in health care spending: it merely requires that spending grow more slowly than it has in recent years.

Second, we look to Massachusetts that has the longest experience with a cost growth target:

- The rate of employment of health care workers per 1,000 in Massachusetts grew from 2014 until the pandemic year of 2020 and has rebounded since[11].
- Wages for health care workers in Massachusetts have also grown over this period[12].

Third, the goal of OHCA is to reconfigure the delivery of care to achieve better outcomes and improved equity through measures such as alternative payment models as well as increased access to primary care and integrated behavioral health. Reconfiguration means change.

In a health care market where consumers have a limited ability to refuse care, or even to shop around and compare costs and quality, a cost growth target provides a spur for innovation, for providers to compete to find new ways to provide quality care efficiently and meet the target while ensuring that some of the savings go to consumers, rather than profits and reserves. Beyond utilities, few other industries get to tally up their cost pressures and then charge the sum without consideration for the affordability to the end consumer. Other industries thrive on finding efficiencies, savings and innovation, and we hope the cost growth target helps supercharge those efforts in the health care sector.

Fourth, we note that members of the advisory committee who are front-line workers and supervisors rather than senior administrators, have spontaneously pointed to the waste caused by excessive overhead in many health organizations. Existing law recognizes the need to limit administrative overhead and profits for carriers. There is also proposed legislation to assure that the vast majority of nursing home spending goes to care, not overhead and profits. There are no similar measures for hospitals, health systems, and large physician organizations. How many billions of dollars of administrative overhead, reserves, and available capital are hiding in health systems that are being spent on consolidation and expansion? We do not know. We should.

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[11] US Bureau of Labor Statistics, Current Employment Statistics Survey, computed by UC Berkeley Labor Center.
[12] slide 26

Finally, as noted by Board Member Mitchell, spending that does not go to health care cost growth is available to other parts of the economy, starting with the wages of workers who do not work in health care but also for other purposes of employers.

We support the OHCA targets of 3% for the five years from 2025 to 2029.

The proposed Office of Health Care Affordability targets of 3% will slow the rate of growth. Over time, consumers will spend less as a share of income on premiums, copays and deductibles and will be better able to afford care and coverage.

From a consumer and purchaser perspective, lowering costs more and sooner would be even better. Other states have adopted even more aggressive cost targets and have lowered their cost targets in recent years[13]. OHCA proposes a gradual approach that allows doctors, hospitals, and insurers time to adjust and adapt to the new cost targets.

The OHCA statute and the work of the Office today includes many provisions to improve equity and quality while reducing costs:

- Emphasis on primary care and prevention
- Behavioral health targets
- Measures of consumer affordability
- Alternative Payment Model standards

The goal is to replace the vicious cycle of lack of affordability leading lack of access to care resulting in higher cost care in ERs and hospitals with a virtuous circle of lower costs, better quality and improved equity where Californians can afford their share of premiums and the cost to go to the doctor or get a prescription.

The first step in changing health care costs is setting a target rather than just letting the health care industry charge whatever it wants, no matter how unaffordable for consumers and other purchasers. For these reasons, we support the proposed target,

Sincerely,

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Anthony Wright
Executive Director

[13] Health Care Affordability Board Meeting Slides, Jan 2024

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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
Senator Richard Roth, Senate Health Committee

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