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Health Care Affordability Board
June 26, 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
07/17/2024	Ana Malinow	**See Attachment #1.** Dear Dr. Ghaly, We are concerned about the Office of Health Care Affordability's efforts to control health care spending in California by imposing a cap on per capita health care spending. We propose that you run a pilot test, utilizing expenditure data in California's all-payer claims database on half-dozen health care entities over the course of two years, a base year and a performance year, before rolling out the cap on over 700 health care entities in California. As we write in our letter, we believe a pilot test of the process of setting per capita expenditure caps at the entity level will reveal (1) how difficult it will be to set caps at levels that accurately reflect factors outside entity control, and (2) the high probability that inaccurately risk-adjusted caps, based on a tight cap such as the proposed 3 percent growth cap, will punish entities that insure or treat a disproportionate share of the sick and the poor and reward entities that game the system by insuring or treating a disproportionate share of healthy and well off. We welcome the opportunity to discuss our concerns further with you and appreciate a response to our attached letter in a timely manner.
07/26/2024	Bruce Hector	Aloha Dr. Ghaly, Congratulations on your appointment to OCHA. You have assumed a very challenging position. We may have met while you were with LA County DPH during one of the many sessions concerning the Aliso Canyon Disaster either at Granada Hills High School, another SFV meeting location or over Zoom after Covid closed group meetings. I was the only physician on the Community Advisory Council (CAG) but dealt more directly with Drs. Paul Simon and Mantu Davis. I found both to be cordial, objective and attentive to community desires. Hence, I have confidence that, like them, you seek solutions that are medically

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		sound, evidence based and free of political bias. With that in mind I wish to comment on the tasks before the Office of Healthcare Affordability (OCHA) with the hope that California can finally move toward an improved health care system that will halt the progressive downward spiral of our nation's health care rankings. By way of background, I am a recently retired private practice family physician who, with his internal medicine partner, had practiced since 1976 in the central San Fernando Valley having purchased the practice of the doc who established the first obstetrical beds in the SFV in 1950. Over the course of my career I was Chief of Staff of a small hospital, founded a Federally Qualified Health Clinic (FQHC) called Mission City Community Clinic, was medical director of a large multi-specialty forensic medical group (Parthenia Medical Group) and have participated from the beginning in the myriad of delivery system changes precipitated by the intrusion of third parties all allegedly designed to improve quality and access while reducing cost. Lastly, for the past 15 years I have been involved in several state and national organizations promoting improved quality and access. I also attended numerous online meetings of Gov Newsom's Healthy California for All Commission and reviewed the final report. This experience I believe affords me some insight into past and present system problems which I wish to discuss in the remainder of this correspondence. The OCHA website (https://hcai.ca.gov/affordability/ohca/) notes 3 main missions - slow spending growth, promote high value and assess market consolidation. Subsequent narratives will address each of these. To slow spending, reduction initially to 3.5% annual cost growth is proposed with a target to become 3% by 2029. The report noted this goal was selected to match expected inflation throughout the general economy. It is not noted if the analysis will include assessment of individual cost components of the delivery system or attempt to determine what system components are greater or lesser inflation drivers. It appears all sectors are viewed equally and each expected to reduce costs equally. The presumption that all components are equally inflationary and equally capable of cost reduction without quality compromise may not be valid. Was it selected primarily to promote equality of system component treatment and attention to financial objectives rather than quality? Perhaps inequities are to be addressed later and adjustments made based on experience. This section also does not appear to seek to discriminate medical treatment expenses from administrative, advertising, executive salaries, inflated drug costs and prior authorization programs. In the Healthy California for All Commission Final Report, it was noted that adoption of a Unified Financing system would afford enough savings to not only

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		provide coverage to all California residents but also long term care. Has OCHA now decided such a system cannot be adopted? Likewise, newer treatment regimens may be more expensive but more effective resulting lower cost for treated diagnosis over time and better outcomes. Over the years the often cited inflationary cause is “over-utilization” supposedly by both patients and providers. However, objective evidence to support that U S patients or providers are greater utilizers of healthcare resources is woefully lacking and may therefore be a false premise. This appears to be recognized as noted in the OCHA Fact Sheet citing an article from 2003 by Reinhardt saying “it’s still the prices, stupid”, citing significantly greater commercial health plan provider reimbursement versus Medicare. The OCHA approach appears to focus on cost caps to control inflation moving away from “FFS to value” and from “volume to value”. Such statements suggest OCHA sees over utilization as a problem seemingly contradicting prior conclusions and again emphasizes value without acknowledging the difficulty in defining value. Intuitively, best measures of value are system population related information gathered over prolonged periods like life span extension, hospitalizations, early illness diagnosis and successful intervention resulting in lower cost per diagnosis over an extended period. How does OCHA think cost caps will help move from volume to value? Could it not just as easily result in reduced care to high liability persons? The OCHA goal to improve quality identifies 5 focus areas - primary care and behavioral care investment, Alternate Payment Methods (APM), workforce stability and quality and equity performance. Here I will only briefly discuss APMs. As a PCP, I have received capitation payment from insurers and medical groups for years. I also watched these entities approach me offering financial incentives to me if I coded billing in a particular fashion or ordered specific tests or immunizations that were being rewarded by their payors. When I inquired about the financial incentive provided to the program for my cooperation in the program, they refused to divulge their cut. Transparency has never been a strong element of insurers, HMO’s and even provider organizations. With capitation I also discovered that the most time consuming patients were not always the most ill but what I called the “worried well”. Others were quite demanding of diagnostic services they had heard about and in need of detailed explanation of why best care practice need not include extensive diagnostic testiing. Such patients may not be High Risk from a health plan perspective but at High Risk of demanding a provider’s time, a critical financial component. What tool can accurately capture this additional needed provider effort? Value and quality of service should include patient communication and

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		satisfaction. How can these be measured? Does OCHA plan to also examine the cost associated with provider time completing forms, paying additional staff to collect and submit them, filing prior authorizations and appeals? What about corporate expense of advertising, review personnel, executive salaries and marketing programs? Medicare Advantage plans typically have 12 - 15% administrative costs compared to Medicare at 3 - 4%. Does OCHA have a plan to reduce this cost or does it expect all anticipated savings to come from provider patient-care alterations? All alternate payment methods require some form of “risk assessment” of each patient to determine who is to be a likely high or low system utilizer so that fair and reasonable provider compensation may be provided for each. Initially, sex and age were the selected risk factors but when this proved inaccurate health status by diagnoses was added. This led to extensive “upcoding” by providers using the “incentives” noted above without really improving risk adjustment accuracy or saving the system money. Research shows that accurate risk assessment may be impossible due to some well recognized factors. For example, on an annual basis, research has established that 20% of patients account for 80% of annual costs. One year a person may be a high utilizer, the next minimal. As an otherwise healthy senior who has had 2 hip replacements, this was experienced by me. As noted above, there is no evidence that overutilization by patients is the inflationary cause. If APM must rely on risk assessment and no tool useful exists yet to accomplish this, APM may be doomed to fail. The last element mentioned at the OCHA website is Assess Market Consolidation. I have also observed this phenomenon over the last 25 years from a provider perspective. During these last decades, significant provider changes have occurred and trends become evident including marketplace consolidation. Federal and state regulations have also allowed more profit seeking entities to enter the marketplace under the presumption that competition will produce better quality at a more affordable cost. Indeed, the whole HMO movement was started under a presumption that “Managed Care” would improve quality and reduce cost. From this we got Medicare Advantage now more than 40 years old. Unfortunately, this has not resulted in any significant cost control and while some factors like enrollment numbers may suggest success, overall no healthcare improvement has been documented nor has healthcare inflation slowed. So far Medicare Advantage has only been beneficial for corporate stockholders. Most providers have been aware of this consolidation process with many private practices being purchased by corporations, more salaried providers, providers being asked to care only for corporate subscribed “network” patients and refusal of programs to enroll provider patients at

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		high risk no matter how long they have received care. How does OCHA plan to assess quality change for these patients? Can it even track the effect of marketplace changes on them? Further, these same corporate entities have been found to be the biggest system abusers costing Medicare an extra $50 billion (https://finance.yahoo.com/news/insurers-bilk-medicare-50-billion-230658994.html.). Obviously, corporations are in the health care business to make money for stockholders. That is money not providing care. What evidence does OCHA have that corporate based providers can add value without system cost inflation? Studying to see if marketplace consolidation has played a role is laudable but how will OCHA respond if it learns that consolidation has worsened the problems? I do not relish your job and you have certainly taken on a formidable challenge. From a broad perspective, it is clear that other nations have learned how to provide quality care at a a lower cost. Does OCHA plan to examine their systems? There likely are reasons why healthcare costs twice as much in the US. According to one report from 2023, the US now ranks number 69 of 167 participants in an international survey, down from number 39 just a decade ago. (https://www.statista.com/statistics/1376359/health-and-health-system-ranking-of-countries-worldwide/). “Business Insider” notes the US is not among the top 19 nations on it’s best healthcare list (https://www.businessinsider.com/the-healthiest-countries-in-the-world-according-to-legatum-2018-2#7-norway-norway-along-with-its-scandinavian-counterparts-often-comes-close-to-global-quality-of-life-rankings-and-one-reason-is-the-health-of-its-citizens-the-countrys-healthcare-system-is-free-for-children-under-16-but-adults-must-pay-for-services-the-country-spends-more-per-person-on-healthcare-than-any-other-country-on-earth-13). Clearly, there is abundant room for improvement. My fear is that if OCHA’s assumptions are wrong, especially about risk assessment and acceptable options are only explored within the constraints of corporate for-profit motivated participants, any pursued goal based on those assumptions will fail. By my observation, that is largely what has happened over the last 40 years much to the detriment of the original goals of the Medicare and Medicaid programs. This policy also appears to neglect the Healthy California for All Report recommendations. In conclusion, I believe there are sound, evidence based solutions that will result in cost reduction, improved quality and assured access for all fulfilling the promised goal of Medicare. I would welcome the opportunity to meet with you in person or per Zoom meeting. I participate in several state and national healthcare oriented organizations with published experts and would welcome the opportunity for us to present the evidence supporting our opinions to you and your staff.

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		I look forward to a response from you and your office. I offer these comments in support of the difficult task you are facing and offer my assistance. I close noting that a recent survey of Canadians identified Tommy Douglas, grandfather of recently deceased actor Donald Sutherland and founder of the Canadian Healthcare system, also called Medicare, as their most respected citizen. if you are able to really solve America's healthcare problems, you will likely be remembered fondly by future generations (https://www.historyisnowmagazine.com/blog/2020/11/29/tommy-douglas-the-greatest-canadian).
08/12/2024	Kevin Causey	Dear members of the OHCA Board, We welcome the fact that the OCHA Board will be meeting here in Monterey on Wednesday, August 28. However, we are disappointed that payers and patients were invited to participate, and providers were not. We feel that the issues at hand, especially here in Monterey County, are complex and that two minutes as part of public commentary could not provide the proper forum for healthcare providers to articulate our circumstances that impact the issues at hand. Thus, we would very much like an opportunity to address members of the Board directly. I invite the appropriate number of members of the OHCA Board to join members of our senior leadership team for a lunch meeting (or breakfast, if that's preferable) and a tour of the hospital during your visit. We will walk through the operations of our system, an overview of revenues, expenses and the scale of the population health work we do. And, of course, we will address any concerns Board members have, and answer any and all questions they may have. Please let me know if members of the Board would be willing to attend.
08/21/2024	UC Berkeley Labor Center	**See Attachment #2.**
08/23/2024	Beth Capell on behalf of Health Access California	**See Attachment #3.**
8/23/2024	California Hospital Association	**See Attachment #4.**

Attachment #1

July 18, 2024

Dear Dr. Ghaly,

Although we share OHCA's goal of reducing health care costs, we are deeply concerned about the methods by which OHCA plans to reduce the state's health care spending. We are writing to suggest that OHCA immediately conduct a test of its proposal to subject 33 insurance companies, 400 hospitals, and approximately 300 physician groups, aka "health care entities," to annual expenditure caps. Under OHCA's current proposal, OHCA will set a phased-in cap of 3 percent growth in per capita health care spending per year for the entire state and for individual entities as well, and OHCA will adjust per capita expenditures by health care entities using only age and sex to determine whether entities exceeded the 3 percent cap.

Section 127502.5(a) of SB 182, the 2022 law that established OHCA, requires OHCA to "consider each entity's contribution to cost growth in excess of the applicable target ... and the *extent to which each entity has control over the applicable components of its cost target* [emphasis added]." We believe a pilot test -- a simulation of the process of setting per capita expenditure caps at the entity level -- will reveal (1) how difficult it will be to set caps at levels that accurately reflect factors outside entity control, and (2) the high probability that inaccurately risk-adjusted caps, based on a tight cap such as the proposed 3 percent growth cap, will punish entities that insure or treat a disproportionate share of the sick and the poor and reward entities that game the system by insuring or treating a disproportionate share of the healthy and well off.

OHCA has no method of accurately adjusting entity expenditures to reflect the health of the entities' enrollees (in the case of insurers) or assignees (in the case of providers) (see further discussion of risk adjustment below). If OHCA cannot determine whether an entity exceeded its cap because of factors within or outside the entity's control, OHCA will be unable to give the offending entity advice on how to comply with its cap, and OHCA will be unable to judge the adequacy of the "performance improvement plans" OHCA is authorized to require offending entities to file. Of course, entities that exceed their caps will be as uninformed as OHCA: Entities will know they exceeded their cap but they will not know whether the cause was within or outside their control, and they will therefore have no idea what to propose in a "performance improvement plan."

We recommend that OHCA should determine now whether the statements above are accurate. OHCA should not wait till 2028 to determine whether we are correct.

The pilot test we are suggesting could utilize expenditure data in California's all-payer claims database on a half-dozen entities over the course of two years, a base year and a performance year, say 2018 and 2019. The test should include safety net hospitals, addiction clinics and other providers that serve a disproportionate share of the sick and the poor. It might test two scenarios, each using the 3 percent growth limit currently endorsed by OHCA as the cap for statewide spending. One scenario would test how accurately a risk adjuster using just age and sex adjusts entity expenditures for factors outside provider control (in other words, how accurately age and sex raise or lower the providers' per capita expenditures vis-à-vis the state per capita average as of 2018 increased by 3 percent). The other scenario would test how accurately a risk adjuster that uses diagnoses (in addition to age and sex) adjusts entity expenditures for factors outside provider control.

The results of both simulations should reveal to you how grossly inaccurate risk adjustment is, even

risk adjusters that use diagnoses, and, therefore, how uninformative entity-level risk-adjusted expenditures will be. They will be uninformative (in the case of the age-sex risk adjuster, worthless) because no risk adjuster in use today can predict (explain) much of the variation in spending between individuals. The diagnosis-based risk adjuster CMS uses to risk adjust payments to Medicare Advantage plans, known as the Hierarchical Condition Categories (HCC) adjuster, is probably the most analyzed risk adjuster in the world, and yet it has explained only 11 to 13 percent of the variation over the last decade.[1] The accuracy of the HCC is probably substantially lower when it is applied to people of all ages because the percentage of the non-elderly who have acquired a diagnosis is much lower than the percentage of the elderly who have received diagnoses. Age and sex, on the other hand, explain less than 1 percent.[2]

To understand the consequences of risk adjustment that can only predict 11 percent of the variation in spending, consider these results reported by the Medicare Payment Advisory Commission (MedPAC) in its June 2014 report to Congress. MedPAC divided a sample of Medicare beneficiaries into quintiles based on their health status. It also examined spending by the sickest 1 percent. It determined that the HCC overpaid for the healthiest quintile by 62 percent and underpaid for the sickest one percent by 21 percent.[3] Adding more diagnoses does almost nothing to improve the HCC.[4] Nor does adding social determinants of health. Here for example is MedPAC's conclusion about the value of adding two of the most obvious social-determinants-of-health variables, race and income, to the HCC: "The addition of race and income variables to the standard model did very little to enhance its predictive accuracy. Using the standard CMS–HCC model, we obtained an R2 [R squared] of 0.1100. Adding race and income variables had no effect on the R2."[5] Bowers et al. concluded in a 2023 study that the Area Deprivation Index (ADI) did not improve the accuracy of the HCC. "We found that the ADI of a beneficiary's residence, a commonly used measure of community-level social risk, was weakly correlated with health care spending, explaining only 0.02% of the variation in spending observed among [Medicare Advantage] beneficiaries in 2019."[6]

In an October 18, 2023 letter to you, the California Hospital Association (CHA) delivered a warning much like the one we are articulating. Unfortunately, because the letter implied accurate risk adjustment is possible, the letter was misleading. The letter stated: "At the September board meeting, OHCA announced its decision to risk adjust health care entities' spending data only on the basis of age and sex. With this decision, OHCA will forego clinical risk-adjustment approaches that perform orders of magnitude better than age and sex in explaining variation in health care spending. We worry that this will expose health care entities to potential enforcement action due to forces beyond their control—in this case, year-to-year fluctuations in the risk profile of their patient populations. In doing so, the spending target program will disincentivize health care entities from serving the highest risk and cost patients, which is inconsistent with supporting an equitable health care system." CHA went on to "recommend that OHCA instead perform both clinical and non-clinical adjustment during initial implementation to test which approach is better suited to achieving OHCA's objectives...."[7]

We agree with CHA's statement that diagnosis-based risk adjusters perform far "better than age and sex in explaining variation in health care spending." But performing better than 1 percent is woefully insufficient. Moreover, as OHCA already knows, adding diagnoses to risk adjusters induces upcoding, possibly so much upcoding that any reduction in overpayments achieved by the increased accuracy of the risk adjuster (from 1 to 11-13 percent in the case of the HCC) is more than offset by higher payments induced by upcoding.

The issues raised by OHCA's plan to impose tight caps on hundreds of California health care entities are complex. We are confident that OHCA's proposal to impose a 3 percent growth cap on all entities, and then attempt to adjust entity expenditures with either age and sex alone or with a diagnosis-based risk adjuster like the HCC, will have multiple toxic outcomes, the worst of which will be worsening of disparities. However, we urge you to test our assertions by conducting a simulation using data on a half-dozen entities collected during a base year and examining how well risk adjustment reveals why some entities exceeded the 3 percent cap in a subsequent "performance" year. If the simulation indicates entity-level spending, however risk adjusted, tells you almost nothing, we urge you to research our assertion that risk adjusters cannot be improved, and if your research confirms that risk adjustment cannot be substantially improved, to let the legislature know that SB 182 essentially asks OHCA to accomplish the impossible and to look for another method of cost containment.

We have other concerns about OHCA's proposal to set per capita spending caps on individual health care entities, including inaccurate "attribution" to provider entities, inaccurate measurement of out-of-pocket spending, OHCA's inability to detect expenditures triggered by upcoding induced by payers that use diagnoses to adjust provider payments, the insertion of yet another layer of costly and burdensome bureaucracy into an already complex and bureaucratic system, and OHCA's endorsement of the unfounded belief that alternative payment models will help entities achieve their spending targets.[8] [9] We may address these issues in a future letter.

In summary, we the undersigned request that you test OHCA's proposal to set per capita expenditure caps at the entity level by conducting a pilot test using expenditures by a half-dozen entities during a base year and a performance year. Results of this pilot will shed light on whether SB 182's mandate, and OHCA's proposal, are feasible without forcing OHCA and hundreds of entities to waste time and resources on a questionable experiment.

Sincerely,

Corinne Frugoni, MD
Co-chair, Humboldt County Physicians for a National Health Program/ Health Care for All (HCA)

Nancy Greep, MD
Chair, Santa Barbara Chapter of Physicians for a National Health Program

John Hirshleifer, MD, MPH

Ana Malinow, MD
Lead Organizer, Movement to End Privatization of Medicare

Kip Sullivan, JD
Advisor, Minnesota Physicians for a National Health Program

[1] Centers for Medicare and Medicaid Services. Report to Congress: Risk adjustment in Medicare Advantage. Dec. 2021. Table 2-1, p. 11. Report to Congress: Medicare Advantage Risk Adjustment - December 2021 (cms.gov). (Accessed 4/30/2024.)

[2] Gregory Pope et al. Risk Adjustment of Medicare Capitation Payments Using the CMS-HCC Model. Health Financing Review. Summer 2004. Vol. 25. No. 4. p. 119. Pope (cms.gov). (Accessed 4/20/2024.)

[3] Medpac. Report to the Congress: Medicare and the health care delivery system. June 2014. Improving risk adjustment in the Medicare program. Chapter 2. Table 2-1, p. 30, "Standard model" column, bottom half. jun14_ch02.pdf (medpac.gov). (Accessed 4/30/2024.)

[4] Figure 4, p. 127 Pope et al. cited above.

[5] Medpac. Report to the Congress: Medicare and the health care delivery system. June 2012. Chapter 4, p. 102. Chapter 4: Issues for risk adjustment in Medicare Advantage (June 2012) (medpac.gov). (Accessed 4/30/2024.)

[6] Brian Powers et al. Association Between Community-level Social Risk and Spending Among Medicare Beneficiaries. JAMA Health Forum. 2023 Mar; 4(3): e230266. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10066453/ (Accessed 4/30/2024.)

[7] California Hospital Association. Comment on the September 2023 OHCA Board and Advisory Committee Meetings. October 18, 2023. https://calhospital.org/wp-content/uploads/2023/10/CHA-Comment-Letter-on-September-Health-Care-Affordability-Board-Meeting_Final.pdf (Accessed 4/30/2024.)

[8] Andrew Ryan et al. Estimated Savings from the Medicare Shared Savings Program. JAMA Network. Dec. 15, 2023. Estimated Savings From the Medicare Shared Savings Program | Health Policy | JAMA Health Forum | JAMA Network (Accessed 4/30/2024.)

[9] Congressional Budget Office. Federal Budgetary Effects of the Activities of the Center for Medicare and Medicaid Innovation. Sept. 2023. Federal Budgetary Effects of the Activities of the Center for Medicare & Medicaid Innovation | Congressional Budget Office (cbo.gov) (Accessed 4/30/2024.)

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August 21, 2024

Mark Ghaly, Chair, Health Care Affordability Board

Elizabeth Landsberg, Director, Department of Health Care Access and Information

Vishaal Pegany, Deputy Director, Office of Health Care Affordability
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Sacramento, CA 95833

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

The UC Berkeley Labor Center is a public service and outreach program of the Institute for Research on Labor and Employment, founded in 1964. The Labor Center's health care research program aims to inform policy making related to access to health coverage and health care affordability for workers and their families.

We submit these comments in advance of the August 28, 2024 Board meeting to be held in Monterey County, a fitting location for OHCA to discuss health care affordability given the many workers who have shared with the Board their compelling and concerning stories about the health care affordability challenges they face at the three hospitals in Monterey and Salinas: Community Hospital of the Monterey Peninsula (CHOMP, part of Montage Health), Salinas Valley Health, and Natividad. Our review of the available data reinforces the severe health care affordability challenges related to hospital prices in the Monterey and Salinas area, as we summarized in our September 2023 blog post "Why are health care prices so high for workers in Monterey County?" and as we describe in this letter.[i]

Monterey has among the highest hospital prices in the state

An analysis by Health Care Cost Institute showed that the Salinas metropolitan area, which includes Monterey, had the highest Inpatient prices and the second highest Outpatient hospital prices of any of the metropolitan areas analyzed nationwide in 2021.[ii]

RAND analysis of hospital claims data[iii] collected from participating self-insured employer health plans around the country shows that from 2020 to 2022 the employer-plan prices for care at Monterey/ Salinas hospitals were higher than the typical California and Bay Area hospitals:

- For inpatient and outpatient services, prices were 4.7 times Medicare prices at CHOMP, 4.2 times at Natividad and 3.4 times at Salinas Valley Health, compared to 2.7 times

Medicare prices for the median California hospital and 3.1 times Medicare prices in the high cost-of-living Bay Area; and

- For inpatient services only, prices were 5.4 times Medicare prices at CHOMP, 4.5 times at Natividad and 3.6 times at Salinas Valley Health, compared to 2.6 times Medicare prices for the median California hospital and 2.7 times Medicare prices in the high cost-of-living Bay Area.

Covered California premiums in the Monterey, San Benito, and Santa Cruz region were higher than in any other Covered California region between 2020 and 2024. In 2025, average rates in that region will grow by 15.7%, the highest growth of any Covered California region.[iv] Hospital prices are likely a significant factor in these higher premiums given that hospital care made up approximately 37% of private health insurance expenditures in the U.S. in 2021, more than physician and clinical services (27%) and prescription drugs (13%).[v] Additionally, research has shown that it's primarily price growth, not changes in utilization, that drives health care spending growth.[vi]

These high health care prices can inhibit access to care and cause financial problems for workers and their families, while also putting a squeeze on their wage growth.

Market concentration has been associated with high prices

Research has shown that the level of competition in hospital markets is correlated with prices. A study by Cooper, Craig, Gaynor, and Van Reenan found that monopoly hospital markets with one hospital within a 15-mile radius (relevant to CHOMP) are associated with prices that are 12.5% higher than in markets with four or more hospitals. Duopoly markets with two hospitals within 15 miles (relevant to Natividad and Salinas Valley Health) are associated with prices that are 7.6% higher.[vii] The price gap between Monterey hospitals and hospitals in markets with more competition is likely even greater than these national findings for typical monopoly/ duopoly hospitals indicate, but this study suggests that concentration is likely a significant factor in the high cost of hospital care in Monterey County.

The Herfindahl-Hirschman Index (HHI) is a measure of market concentration used by the U.S. Department of Justice and the Federal Trade Commission in evaluating mergers. The index is on a scale of 0 to 10,000, with higher numbers signifying greater market concentration. HHI estimates for hospitals in the Monterey region vary based on the methods and definition of the market–from 3,339 based on UC Berkeley Petris Center analysis of American Hospital Association Annual Survey Database with the market defined by the county, to in the range of 6,000-8,000 based on estimates analysis by the Yale Tobin Center for Economic Policy with the market defined as all hospitals within a 30-minute drive time.[viii] Using either estimate, the market is considered highly concentrated because it has an HHI of more than 2,500.

Understanding market concentration in the area helps to at least partially explain why these hospitals can obtain higher prices–patients in the region have no other options–but it does not explain how the revenues from the higher prices are spent.

Does spending at Monterey hospitals differ significantly from that of other hospitals?

We have examined publicly available data for certain key spending categories like wages and uncompensated care costs. In both categories, any spending differences found do not appear significant enough to explain the large price differences.

Wages for health care workers are similar between the Salinas, California, metropolitan area (which includes the city of Monterey and surrounding area) and the state as a whole; therefore this factor likely does not explain a lot of the price difference. The median hourly wages for physical therapists and medical assistants in the Salinas area were below the statewide median in May 2023, based on analysis of data from the U.S. Bureau of Labor Statistics. The Salinas area median wages for registered nurses, LPNs/LVNs, and nursing assistants were 1% to 3% higher than the statewide median wages for these occupations.[ix]

Uncompensated care costs, including bad debt, charity care, and expenses related to county indigent care programs, as a share of operating expenses were higher at Natividad (3.3%) and Salinas Valley Health (2.2%) than the state hospital average (1.8%) in 2022, but not different enough to significantly explain the higher-than-average prices. At CHOMP, uncompensated care costs as a share of operating expenses were below average (0.9%), according to hospital financial data reported to the California Department of Health Care Access and Information.[x]

How does payer mix factor in?

In 2022, public payers paid for 71% of hospital discharges at CHOMP, 76% at Salinas Valley Health, and 82% at Natividad, compared to 72% of hospital discharges statewide, based on data reported by hospitals to the state.[xi] (Public payers include Medi-Cal, Medicare, and, where applicable, county indigent programs.) Could the higher employer-plan prices in this region reflect cost shifting from Medi-Cal or Medicare?

It is difficult to definitively address this question for specific hospitals, however the common assumption that hospitals charge private payers more to make up for public payer shortfalls has not been borne out in the research. A large body of economic research has failed to find evidence of hospitals shifting costs from public payers to private payers.[xii]

A recent national analysis by RAND found that:

> "there is not a strong relationship between [commercial] hospital prices and the share of patients covered by non-private prices. The relationship between a hospital's share of its discharges from non-private payers and relative prices charged to commercial payers is not statistically significant. The absence of a strong correlation between hospital prices and payer composition does not support the hypothesis that higher hospital prices are in place to offset underpayments by public payers or hospitals' expenses for uncompensated care."[xiii]

If high commercial prices resulted from having large shares of Medi-Cal patients, California public and district hospitals–which generally have a high Medi-Cal share of patients–would charge the highest commercial prices, but a 2019 analysis by Rick Kronick and Sarah Hoda Neyaz primarily using HCAI financial data found that public and district hospitals had lower private to Medicare payment-to-cost-ratios (1.44 and 1.83 respectively) than non-profit and investor hospitals (2.23 and 2.05 respectively).[xiv]

It is also worth noting that the federal Medicare Payment Advisory Commission (MedPAC) found that Medicare payments to hospitals were near cost for relatively efficient hospitals in 2021,[xv] suggesting that CHOMP, which has a higher-than-average share of Medicare discharges (54% compared to 39% statewide) should not need to charge so much more to compensate for disproportionately high Medicare patient loads.

What can OHCA do?

While OHCA does not have statutory authority to consider the fullest range of policy options that could reduce regional price variation or address high-cost outlier entities, OHCA has meaningful authority to at least partially address the health care affordability challenges in Monterey.

Adjust targets downward for high-cost outliers

OHCA has statutory authority to "adjust cost targets downward, when warranted, for health care entities that deliver high-cost care that is not commensurate with improvements in quality, and upward, when warranted, for health care entities that deliver low cost, high quality care."[xvi] To begin to address the severe affordability problems in Monterey County, OHCA could use this authority to adjust the spending targets to less than 3.0%-3.5% for some or all of the Monterey/ Salinas hospitals.

In identifying a broader set of outliers, OHCA could set a particular "relative price" threshold to identify high-cost outlier entities in the commercial market. In RAND's hospital price analyses "relative price" means the amount a private insurer pays divided by the Medicare allowed amount for the same service at the same hospitals.[xvii] OHCA could likely use data from the Health Care Payments Data Program to conduct this type of analysis.

Increase public understanding of drivers of spending

One of OHCA's charges in statute is "analyzing the health care market for cost trends and drivers of spending."[xviii] This is critical for understanding the rate of spending growth and why spending levels and growth vary between entities, industries, or regions. This type of analysis will illuminate whether data supports entities' assertions about why they are high-cost entities or, once performance assessment begins, why spending on particular entities exceeds the target. Examples of questions for Board and staff consideration include:

- For the market as a whole, how will OHCA identify the most impactful and the most common drivers of health care spending growth?
- As discussed above, the available research finds little relationship between payer mix and commercial price levels, yet cost shifting continues to be a commonly asserted provider explanation for high spending levels or spending growth. How will OHCA address payer mix, if at all, in evaluating performance against the target?
- If entities identify labor costs as a major driver of spending growth, how will entities be asked to substantiate those trends?
- How will uncompensated care factor into comparison of performance against the target, if at all?

These are longer-term questions that do not necessarily need to be fully answered for OHCA to play a role in addressing the urgent affordability crisis in Monterey, but the Monterey case study helps to illuminate the types of provider assertions that are likely to arise in OHCA's broader work. Addressing questions like these could help to focus attention on particular drivers of spending that are most impactful, and could also serve to center data-driven findings over anecdotes.

Conclusion

Since the first OHCA Board meeting in March 2023, many workers from Monterey County have trekked to Sacramento to describe the struggles they face affording health care in a region with among the highest-priced hospital care in the state. The worker testimonies and the available data demonstrate the extent to which Monterey is an outlier when it comes to high hospital prices, even in a state in which health care affordability problems are widespread.

The upcoming Board meeting presents a vital opportunity for OHCA to begin to play a role in communities struggling with affording care from high-cost outlier entities and/or entire high-cost outlier health care markets. This month's meeting will begin the process of exploring the real drivers of health care spending in a data-driven way. It is our hope that in the coming weeks and months, OHCA staff and Board will continue this data-driven analysis, and make strategic decisions about how it will measure and enforce statewide spending targets and establish spending targets for high-cost outliers.

Sincerely,

Laurel Lucia
Director, Health Care Program

Miranda Dietz
Policy Research Specialist

Endnotes

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[xvii] RAND, Hospital Price Transparency Study Round 5, May 2024, https://www.rand.org/health-care/projects/hospital-pricing/round5.html

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HEALTH ACCESS CALIFORNIA

August 23, 2024

Dr. 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

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

Re: Health Care Affordability Board: August 2024 at Monterey, California Sectors, Consumer Affordability and Rate Review, Behavioral Health

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

Health Access, the statewide health care consumer advocacy coalition offers comments for the August 2024 Health Care Affordability Board meeting in Monterey on considerations for defining sectors, consumer affordability and rate review, as well as behavioral health.

In this letter, we offer two different approaches to defining sectors because of the Board's visit to Monterey, which has very high hospital costs. We also point to the need for the Office and the Board to track the impact of their work on consumer affordability in terms of share of premium and out of pocket costs such as deductibles, copayments, and coinsurance, as well as the need to connect OHCA's cost growth targets to the rate review processes at the Department of Managed Health Care and the Department of Insurance. Finally, we offer comments on the emerging work of the Office on behavioral health.

Consideration of Sectors: Possible Approaches

Since its first meeting, the Health Care Affordability Board has heard from consumers in Monterey County about the lack of affordability driven by excessively high hospital costs from the three hospitals in Monterey and Salinas. Those hospitals are now extending their reach, and those high costs, to physician groups and other health care providers in the county, using consolidation to drive up costs even more.

Health Access is pleased that the Board, and the staff, have responded to the outpouring of stories and testimony from teachers, hotel workers, farm workers, and other consumers in Monterey County who face the very real consequences of high hospital costs by coming to Monterey to hear from more of them. Independent analyses such as the Rand Studies of hospital costs indicate that hospital costs in Monterey are the highest or among the very highest in the United States[1].

The occasion of the meeting of the Health Care Affordability Board in Monterey on August 28, 2024, raises the question of "sectors," how that term should be defined, and what approach makes sense. What follows is intended as the beginning of a discussion rather than a definitive proposal. The OHCA law provides some possible directions but does not

[1] https://www.rand.org/health-care/projects/hospital-pricing/round5.html

define "sectors[2]". The law leaves the decision about defining sectors almost entirely to the discretion of the Board. If the Board chooses to define sectors, OHCA will be setting national precedent: no other state has attempted to distinguish among entities, regions or outliers in setting its cost targets.

Sectors: California First to Define, the Board Decides

No other state faces the challenges of large scale posed by California. Some of the 19 Covered California regions which OHCA will use for public reporting have populations greater than the majority of states[3]. In smaller states like Maryland and Massachusetts, the CEOs of all the hospitals in that state could convene in the morning and be home in time for dinner, something that is literally inconceivable in California with more than 400 hospitals. Most observers do not consider Maryland or Massachusetts "small" in comparison to the dozen or so states with only one or two million in population.

The law mentions the possibility that sectors may include "geographic regions and individual health care entities". It could also include industry categories such as hospitals or health systems, physician groups or other types of industry cost segments.

More profoundly, the concept of "sectors" in the law was aimed at identifying high-cost entities that provided no greater value, no better outcomes, and no increase in equity. Those who crafted the OHCA statute understood well that costs in some geographic regions and for some parts of the health care industry were far higher than for other regions or other parts of the health care industry, without any concomitant improvements in quality though perhaps more pleasant interior decoration.

We explore in turn an approach based on sectors defined as regions and types of entities as opposed to an approach using the frame of high-cost outliers.

Regions, Doctors, Hospitals, Drugs and Technology

The OHCA enabling statute leaves the definition of "sectors" to the Board, with the input of staff and the Advisory Committee. The law permits but does not require "sectors" to include geographic regions and individual health care entities. It would also permit sectors to include physician groups, health systems or categories of hospitals such academic medical centers, children's hospitals, high public payer hospitals (over 90% Medicare and Medi-Cal[4]), small and rural, and community hospitals by size. It would permit "sector" to be an individual health care entity such as a hospital system or even an individual hospital.

This suggests one approach to defining sectors which would be to break the state into geographic regions and to look at the key elements of spending, including physician groups, hospitals, drugs and technology. But what about health systems such as Adventist or CommonSpirit or the University of California? And in what order do you consider the proposed sectors: does it matter more that a doctors' group is in Redding or that a hospital is based in Pomona? Or that it is a doctors' group or a hospital or part of a health system? Depending on the type of statistical analysis, which variable is analyzed first can affect the outcome of the analysis. Pretty quickly, the analysis can drown in administrative complexity and become inexplicable to most observers, including policymakers such as legislators as well as those who are subject to the targets.

The law attempts to address that by stating that sector targets shall specify which single sector target is applicable if a health care entity, say a hospital in Monterey, falls within two or more sectors[5]. In that case, a hospital in Monterey either has the cost target for Monterey, the cost target for hospitals or the cost target for that entity. If a health care entity falls within two or more sectors, then our proposal would be that the cost

[2] See appendix for relevant citations from the statute.
[3] https://www.britannica.com/topic/largest-U-S-state-by-population
[4] Labor Code Section 1182.14
[5] Health and Safety Code 127502 (l) (2) (D)

target which does the most to reduce the rate of cost growth, and thus to improve consumer affordability, should prevail

The Board is in Monterey precisely because of the outcry over the very high costs of hospitals in Monterey, costs that appear to be extending to physician groups and other providers in Monterey, with heart-wrenching consequences for consumers in terms of affordability. For over a year now, the Board has heard from consumers in Monterey about the lack of affordability of health coverage created by the excessively high costs in that county.

High-Cost Outliers

The other approach contemplated in the law is to look at high-cost outliers and to adjust the statewide target downward when the high costs do not reflect higher quality, higher acuity, higher social need or higher costs for land or labor. Specifically, the law[6] says:

> The methodology shall allow the **board to adjust cost targets downward, when warranted, for health care entities that deliver high-cost care that is not commensurate with improvements in quality**, and upward, when warranted, for health care entities that deliver low-cost, high-quality care. (emphasis added)

This suggests a very different approach to sectors, that of looking at high-cost outliers and at the other end, areas where underinvestment is obvious in terms of lack of hospital beds and lack of physicians per capita such as parts of the Central Valley and under-served urban areas. Such an approach would be consistent with the law's emphasis on equity and access. Rather than attempting to set targets for over 400 hospitals and hundreds of physician groups, such an approach could use a statewide target or at most a regional target with a handful of regions and look for either end of the spectrum in terms of costs. This approach is not lopping off a small number of outliers, say less than 1% or 2% of the entities, but looking at the 90th or 80th percentile in terms of costs at one end and the 10th or 20th percentile at the other end.

An approach such as this would say the 60% of entities that fall into the mid-range of 20th percentile to the 80th percentile would be bound by either a regional target or a statewide target. But greater scrutiny and higher or lower growth rates would apply to those entities at either end of the cost spectrum.

Implications for Monterey

The Board has heard repeatedly from consumers in Monterey about high health care costs. For 2025, Covered California rates will increase by an average of 7.9% but by almost double that, 15.7%, for the region including Monterey, Santa Cruz and San Benito. This double-digit rate increase comes on a high base, further worsening the damage to consumers in Monterey[7].

While the law does not allow for a negative cost target, it would permit the Board to reduce the cost growth target for a specific health care entity such as a hospital, hospitals or health systems in Monterey from the base target of 3% to 3.5%, to a cost growth target for those entities to much lower than 3%, even as low as 0.1%. The lower growth rate could be in effect for a specified period, say five years, or until such time as those entities came more in line with other hospitals or health systems either in the greater Bay Area or California, preferably measured as a percent of Medicare.

Conversely, the Board has heard from other health systems that represent themselves as relatively low-cost, high-quality providers. From a consumer perspective, we prefer to assure that the benefits of the lower costs

[6] Health and Safety Code 127502 (d) (6)

[7] Fortunately, individual consumers enrolled in Covered California have their cost exposure capped at a percent of income that does not exceed 8% of income and even more happily, for 2025, Covered California enrollees selecting a standard silver plan will have zero deductibles and an actuarial value closer to 80% than 70%, thanks to subsidies funded by revenues from the California individual mandate.

accrue to consumers and other purchasers in the form of lower premiums, lower share of premium, and lower out of pocket costs such as deductibles, copays and coinsurance rather than allow greater cost growth for those who have done what they should in the past. Health Access also recognizes the need to invest in underserved areas, whether urban or rural, and to do so thinking about access to care at a granular level: not all hospitals in the Fresno area are created equal in terms of serving the underserved. The same is certainly true of Los Angeles, the Bay Area or other parts of California.

We offer these comments both because the Board is meeting in Monterey, precisely because of the high costs there, and because a discussion of sectors and the implications of defining sectors have repeatedly arisen in the context of setting the cost targets. We recognize that it will take the staff, the Advisory Committee and the Board considerable discussion and analysis to sort out where to land. That discussion and analysis should consider what incentives are created through the creation of sectors; how those incentives could affect business decisions and consumer impacts including affordability and access to care; as well as providing recommendations on how the use of sectors can reinforce the statewide cost target, rather than create opportunities for certain entities to evade the target. We offer these initial thoughts as an opening for discussion and not as a definitive conclusion.

Consumer Affordability and Rate Review

Tracking consumer affordability measures and connecting the cost growth targets to rate review are central to bringing cost growth more in line with what consumers can afford. The Board has already made an important decision to base the cost growth target on the growth in median family income because of its commitment to consumer affordability. But now we need to pay off that decision by tracking what happens to critical measures of consumer affordability from deductibles and cost sharing to family share of premium as well as assuring that cost growth targets are reflected in the rates paid by consumers and other purchasers. The Office of Health Care Affordability says it all: this law and this agency are designed to improve the affordability of health care. Consumer spending and rates are the proof.

Consumer Affordability

Health Access encourages the Board and staff to include an array of measures of consumer affordability, including both share of premium relative to income and out of pocket costs as well as actuarial value in tracking the impacts of the cost growth targets. If the proof is in the pudding, then consumers should see a slowing of the rate of increase in those costs, particularly for those in higher cost parts of California.

The median deductible and median share of premium for family coverage combined now exceed $10,000 a year[8]. It is untenable for the 80% of California households that live on less than $146,000 a year in income to afford those costs on top of other needs. How does a family making $80,000 or even $100,000 spend more than 10% of their income on health care for commercial coverage? And still afford housing and all the other costs of living? Much less a family living on $40,000 or $50,000 a year when health care costs would take one out of four or five dollars in income. That is intolerable and it is why OHCA was created.

We were dismayed to discover that about 80% of those with employer coverage in California now have deductibles, often of thousands of dollars[9]. Slowing the rate of increase in these costs can provide real, measurable relief to consumers who have seen astronomical growth in their health care expenses have over the last 20 years.

Rate Review

[8] https://itep.org/is-california-really-a-high-tax-state/ and https://laborcenter.berkeley.edu/measuring-consumer-affordability/
[9] https://laborcenter.berkeley.edu/measuring-consumer-affordability/

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To pay off the OHCA work in real change for consumers and other purchasers will require connecting the OHCA growth targets to rate review by state regulators of health insurance and by purchasers for self-insured benefits.

For commercial health insurance, 80% or 90% of the rates are doctors, hospitals and prescription drugs while insurance company profits and overhead are 10% or 20% of the premium dollar. Rates reflect these underlying cost drivers due to increases in costs for benefit categories such as hospital inpatient, hospital outpatient, physician services and other ancillary services, laboratory and radiology[10].

Health Access looks forward to working with both OHCA and the regulators, the Department of Managed Health Care and the Department of Insurance, to assure that the cost growth targets set by OHCA are translated into the rates paid by consumers and other purchasers. Put more simply, in our view, any growth in per enrollee costs for covered benefits that exceeds the applicable cost growth target for that calendar year is a suspect rate increase and should be questioned as such.

We will also ask Covered California to look at proposed rate increases in excess of the cost growth targets. Both Covered California and CalPERS as state purchasers, purchasing coverage on behalf of over 3 million Californians, have a role to play in helping to move California toward higher value care.

Tracking an array of consumer affordability measures and connecting the cost growth targets to rate review is necessary to assure the Office of Health Care Affordability lives up to its name and its statutory mission. Until these basics are in place, we will keep returning to these topics because for consumer advocates, consumer affordability is the point of OHCA.

Behavioral Health: Howling Unmet Need, Lack of Access to Appropriate Care

The OHCA statute tasks OHCA with setting goals for behavioral health in parallel, and literally in the same section of the law, as for primary care. The law includes behavioral health because those of us who crafted the law recognized the howling unmet need of too many Californians, combined with the lack of access to appropriate care, and the failure of commercial health plans to provide adequate access. This continues despite the many efforts of this Administration to improve the law and oversight of commercial health plans.

Determining current funding and setting targets for behavioral health is further complicated by the multiple silos of public program funding for behavioral health as well as consumers being forced to pay out of pocket for behavioral health because of lack of access to timely in-network appropriate behavioral health care.

The private pay aspect of behavioral health, which OHCA has recognized and begun work to track, worsens inequities in access to behavioral health. A family living on $100,000 or $150,000 a year may well have difficulty affording private pay behavioral health, such as counselling. Yet despite the financial burden of private pay behavioral health care, many Californians are forced to make that choice because national studies show that psychiatrists accept insurance at rates approximately 30 percentage points lower than other specialty physicians[11]. Similar results likely apply to non-physician mental health professionals.

Those in the bottom half of the income scale but making more than 138% of federal poverty may face terrible choices between affording other necessities and paying for care for a family member. Those affordability barriers equate to barriers to care.

[10] Health and Safety Code Section 1385.03, in Article 6.2 on Review of Rate Increases. Outpatient prescription drug costs are also subject to rate review: Unfortunately, at this time, California law does not permit setting cost growth targets for outpatient prescription drugs, in part because the federal courts have ruled this is generally preempted under the commerce clause of the U.S. Constitution.

[11] Center for American Progress. https://www.americanprogress.org/article/the-behavioral-health-care-affordability-problem/

The affordability crisis is an issue of equity. Race, ethnicity, language, disability status, sexual orientation and gender identity (RELD-SOGI) are all correlated with income: people of color, families with someone with a disability, the LGBTQ community all face greater challenges of income. These communities also face additional barriers to accessing behavioral health that compound the problems created by high costs, from inadequate networks to lack of culturally appropriate services, and more. When a family or an individual faces multiple disparities in terms of RELD-SOGI, behavioral health needs and challenges multiply.

The discussion on behavioral health needs to start at the same place as the discussion on primary care: what does adequate access to appropriate behavioral health look like in a well-functioning health system? Those of us who crafted the law suspected that answering this question was more challenging than answering the same questions for primary care. Because we thought this, we expected this work to be harder and to take longer than the standards on primary care or alternative payment models. But it all starts with the recognition of the proponents of OHCA that people need care, and they are not getting that care or the right care.

We are pleased to note that the second discussion of the Investment and Payment Workgroup on behavioral health begins to focus on the important questions of unmet need, multiple funding streams, and out of pocket costs. This work will be further strengthened by adding an equity lens, including the lack of equity created by lack of affordable access to appropriate care.

Summary:

- *Sectors*

The law gives the Board authority to define sectors. The law suggests but does not require using regions and entities as the basis for defining sectors. The law also speaks to high-cost outliers: we offer an approach based on looking at the top 10% or 20% of the entities as a direction for focus. Monterey provides an example of hospitals where prices, both inpatient and outpatient, are high-cost outliers, even compared to the Bay Area or Northern California. The law would allow the Board to set a cost growth target for a set of high-cost entities that is lower, and even much lower, than the statewide cost growth target.

- *Consumer Affordability and Rate Review*

Health Access again asks that the Board and the Office track an array of consumer affordability measures, such as share of premium and out of pocket cost sharing.
Health Access proposes that commercial insurance rates subject to rate review by DMHC or CDI should not increase more than the statewide cost growth target.

- *Behavioral Health*

The law tasks OHCA with setting behavioral health benchmarks because those involved in drafting the law recognized the chasm of unmet need as well as the lack of timely access to appropriate care. The Investment and Payment Workgroup has begun to consider the needs as well as the multiple sources of payment and the complicated delivery systems.

Sincerely,

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Policy Consultant

Amanda McAllister-Wallner
Interim Executive Director

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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, Chair, Assembly Health Committee
Senator Richard Roth, Chair, Senate Health Committee
Assemblymember Akilah Weber, M.D., Chair, Budget Subcommittee on Health
Senator Caroline Menjivar, Chair, Senate Budget Subcommittee on Health and Human Services
Insurance Commissioner Ricardo Lara
Mary Watanabe, Director, Department of Managed Health Care
Michelle Baass, Director, Department of Health Care Services

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Appendix: Law on "Sectors"

Section **127501.11.** on duties of the Board:

(a) After receiving input, including recommendations, from the office and the advisory committee, and receiving public comments, the board shall establish all of the following:

(1) A statewide health care cost target.

(2) The definitions of health care sectors, which may include geographic regions and individual health care entities, as appropriate, except fully integrated delivery systems as defined in subdivision (h) of Section 127500.2, and specific targets by health care sector, which may include fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate.

Section **127502** on setting targets:

(a) The board shall establish a statewide health care cost target.

(b) (1) The board shall establish specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate. The board shall define health care sectors, which may include geographic regions and individual health care entities, as appropriate, except for fully integrated delivery systems, and the office shall promulgate regulations accordingly.

(2) The board may adjust cost targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate, when warranted to account for the baseline costs in comparison to other health care entities in the health care sector and geographic region.

(d) *is a further discussion of the methodology for setting the targets, including cost trends and potential adjustment factors. It includes the following:*

> (6) (A) The methodology shall allow the **board to adjust cost targets downward, when warranted, for health care entities that deliver high-cost care that is not commensurate with improvements in quality**, and upward, when warranted, for health care entities that deliver low-cost, high-quality care. (Emphasis added)

(e) The methodology for setting a sector target for an individual health care entity shall be developed taking into account the following:

(1) Allow for the setting of cost targets based on the entity's status as a high-cost outlier.

(2) Allow for the setting of cost targets that encourage an individual health care entity to serve populations with greater health care risks by incorporating all of the following:

(A) A risk factor adjustment reflecting the health status of the entity's patient mix, consistent with risk adjustment methodology developed under subdivision (f).

(B) An equity adjustment accounting for the social determinants of health and other factors related to health equity for the entity's patient mix, consistent with subdivision (g).

(C) A geographic cost adjustment reflecting the relative cost of doing business, including labor costs in the communities the entity operates.

(l) (2) (A) On or before October 1, 2027, the board shall define initial health care sectors, which may include geographic regions and individual health care entities, as appropriate, except fully integrated delivery systems, considering factors such as delivery system characteristics. Sectors may be further defined over time.

(B) Not later than June 1, 2028, the board shall establish specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate, in accordance with this chapter.

(C) The development of sector targets shall be done in a manner that minimizes fragmentation and potential cost shifting and that encourages cooperation in meeting statewide and geographic region targets.

(D) Sector targets adopted under this subdivision shall specify which single sector target is applicable if a health care entity falls within two or more sectors.

California Hospital Association

August 23, 2024

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

Subject: **CHA Comments on the August 2024 Health Care Affordability Board Meeting**
(Submitted via Email to Megan Brubaker)

Dear Dr. Ghaly:

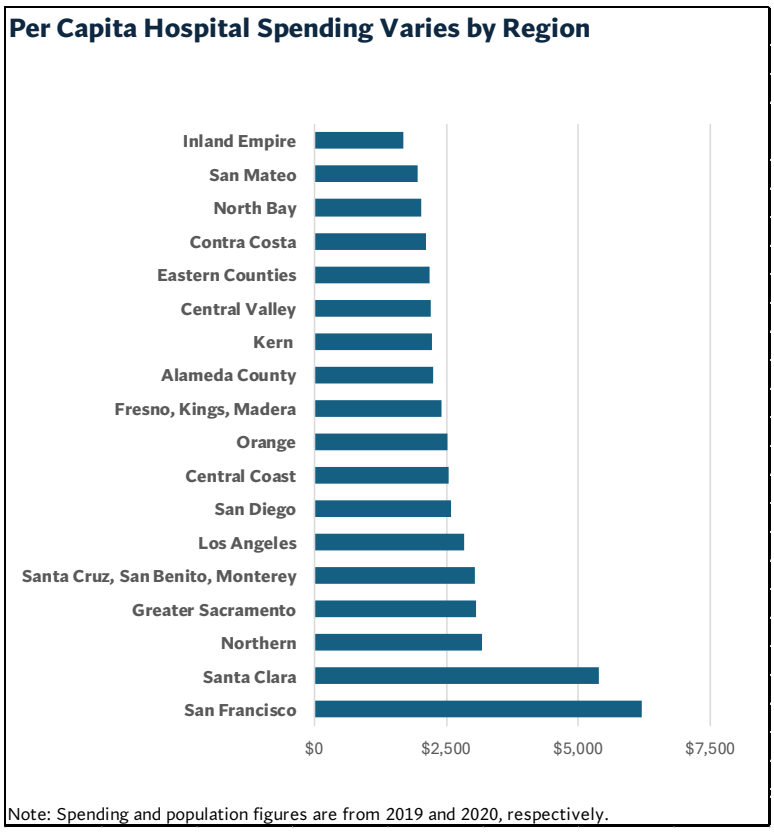
The Office of Health Care Affordability's (OHCA) success in fulfilling its mission of promoting affordability while improving health care access, quality, and equity depends on obtaining a clear understanding of the drivers of health care spending growth. Only then can OHCA appropriately employ its tools to address the real affordability challenges facing Californians while avoiding serious negative consequences. Investigating regional differences in health care costs, as well as their underlying causes, presents a promising approach for identifying these drivers.

On behalf of more than 400 hospital members, CHA encourages OHCA to carefully study the drivers of variation in health care spending across California, the United States, and the globe. Below are some findings related to hospital spending that may inform OHCA's approach to this important topic. Specifically, the letter acknowledges that hospital spending across the state does vary widely. The analysis then shows how this variation closely tracks demographic differences and variation in the general cost of living throughout California.

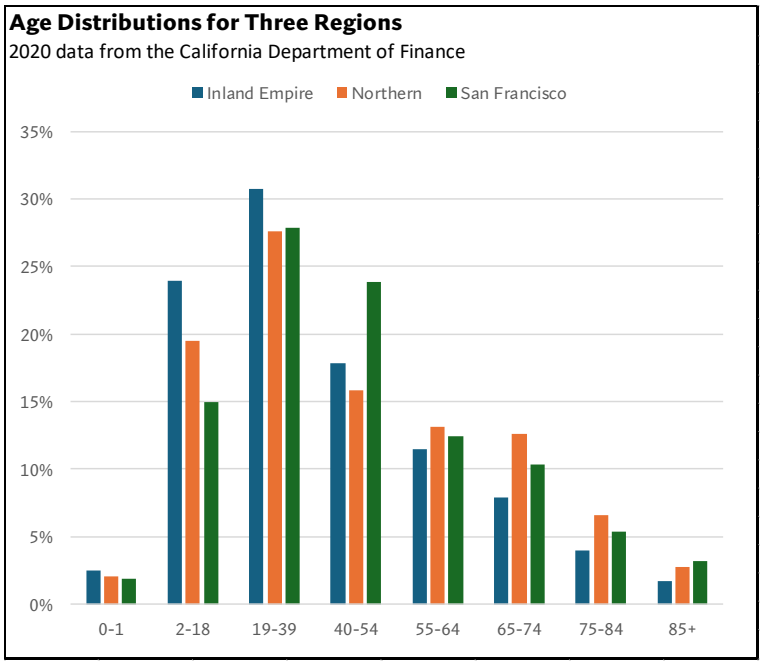
Hospital Spending Varies Significantly Throughout the State. As the figure on the next page shows, hospital spending is roughly $6,200 per resident of San Francisco, which is almost 130% higher than the statewide average of $2,719 per California resident.[1] By contrast, in the Inland Empire, hospital spending is roughly $1,700 per resident, 28% lower than the statewide average. Thus, per capita hospital spending in the most expensive region of the state is 3-to-4 times higher than spending in the least expensive region.

[1] This analysis compares the OHCA region a hospital is in and the residents of that region. The only variance with the OHCA regions is that it aggregates the Los Angeles regions into a single one.

Regions With Older Populations Feature Higher Hospital Spending. A person's chance of visiting the hospital and having a lengthy stay increases dramatically as they age. Therefore, one might expect that regions with older populations would have higher hospital spending. The data bear this out, as regions with older populations also have higher per capita hospital spending. For example, while 16% of California's population is over the age of 64, 22% of the Northern region's population is over 64. By contrast, less than 14% of Inland Empire's residents are over 64. Only knowing the regions' senior population percentage, per capita hospital spending can be predicted to be nearly $850 (33%) higher in the Northern region than in the Inland Empire. Fine-grained differences in age distributions matter as well. San Francisco has the highest population proportion aged 85 and older — this alone predicts per capita hospital spending in San Francisco to be more than $1,200 higher than the state average.



If differences in need drive these differences in spending, data would show that higher spending regions have more hospital utilization. Again, the 2019 data bear this out. For example, San Francisco hospitals have 25% more utilization than the statewide average, as judged on an inpatient-days-per-resident basis. Meanwhile, Inland Empire hospitals have 18% lower utilization than for California residents overall, contributing to the lower spending in the region.



In addition to age, regional differences in disease prevalence, socioeconomic needs, access to primary care, and other factors likely drive differences in per capita spending and deserve further exploration.

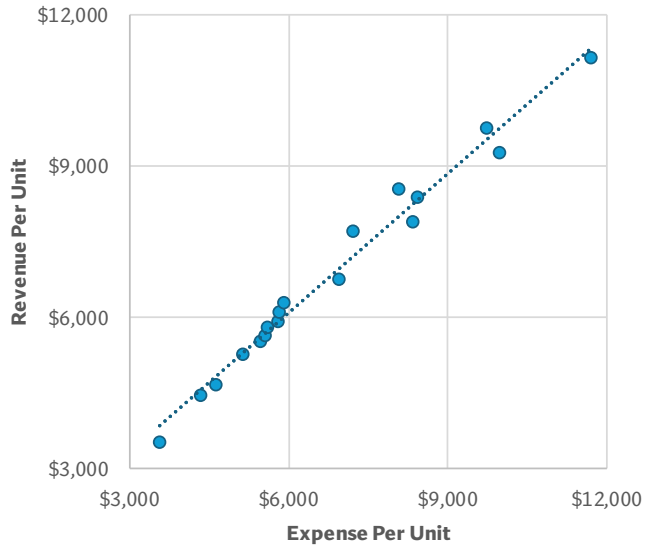
Variation in Reimbursement Levels Explain a Portion of the Difference in Per Capita Hospital Spending. While population health needs explain a large part of the differences in hospital spending across the state,

reimbursement levels play an important role too. It is true that hospitals are paid more in certain regions of the state, like the Bay Area, even after largely controlling for patient acuity and service mix. By contrast, hospital reimbursement is relatively low in the Inland Empire, Central Valley, and in Eastern Counties. However, as shown below, higher reimbursement tracks higher expenses, which are driven by differences in the cost of living across California's different regions.

Higher Reimbursement Does Not Predict Better Financial Performance. It would be reasonable to guess that hospitals in regions with high reimbursement levels perform better financially, such as by having the highest margins. However, the opposite is true. Regions with the highest average reimbursement levels tend to have the lowest operating margins. This surprising relationship is due to the experience of Bay Area hospitals, which collectively lost money over an entire decade from 2010 through 2019 even though their reimbursement levels tended to be higher than in other parts of the state.

Hospital Expenses and Revenues Track Each Other Nearly Perfectly

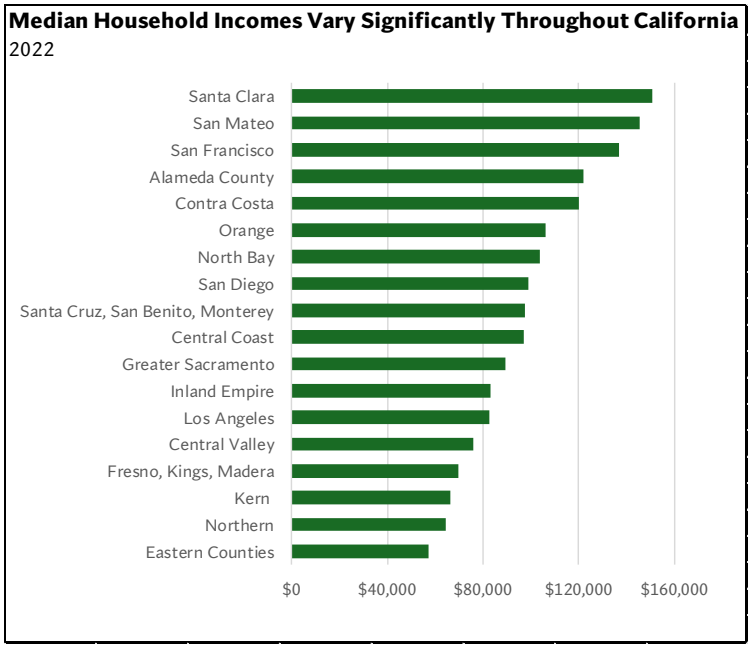
Net Patient Revenue and Operating Expense Per Unit of Service, by OHCA Region, 2010-2019



Hospital Expenses Closely Track Their Revenues. The reason that hospital reimbursement does not predict better financial performance is that for every $1 increase in patient care revenue, operating expenses increase by the same amount, if not slightly more. As a result, cutting hospital spending, from a consumer or purchaser perspective, is not a simple exercise of trimming margins. Rather, to achieve spending reductions, hospitals would have to find ways to cut back on underlying costs, with potential serious negative ramifications for access, quality, and workforce stability.

Hospitals' Largest Expense Is Labor, Which Varies Regionally. Statewide, hospital labor expenses comprise about 50% of total expenses.[2] In certain regions, this share is higher, with hospitals in the Santa Cruz, San Benito, and Monterey region having labor expenses that represent nearly 60% of total expenses. Variation in hospital labor expenses ultimately drives differences in the cost of care, making it no coincidence that Bay Area counties have the highest reimbursement levels *and* the highest labor costs on a per-unit-of-service basis. In contrast, the Inland Empire, Central Valley, and Eastern Counties receive lower reimbursement corresponding almost exactly to their lower labor costs. For example, hospitals in

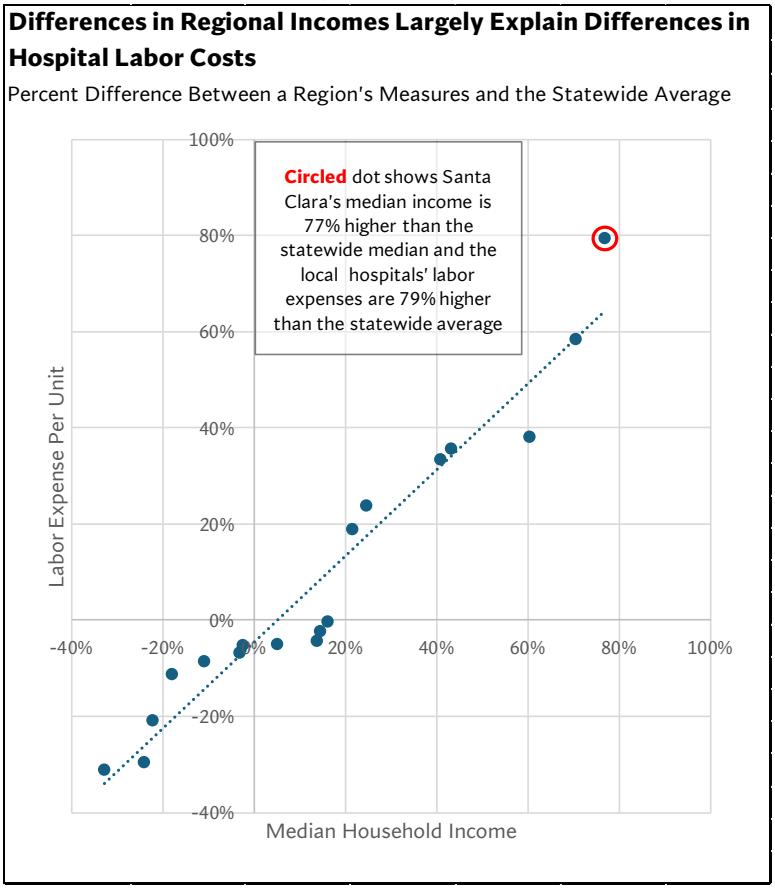
[2] This figure does not include what hospitals pay physicians. When added, hospitals spend closer to 60% of their total expenses on labor.



the Central Valley are paid, on average, 30% less than California hospitals as a whole. They also have labor costs per service that are 30% less than hospitals statewide.

These differences cannot be explained away by higher management salaries. Rather, it is higher non-supervisory worker wages that disproportionately drive the higher labor costs in more expensive regions of the state. Hospitals in regions with lower labor costs dedicate 17% of their salary expenses to manager salaries — compared to 16% in regions with high overall labor costs ("high" and "low" simply compare regions above and below the state average and management is defined broadly, for example, to include direct staff supervisors).

High Area Wages Lead to Higher Hospital Labor Costs. To attract workers, hospitals, like other organizations, must offer wages and benefit packages that consider local economic conditions, including cost of living. One key measure, median household income, varies hugely throughout California. As shown in the figure above, in San Francisco, San Mateo, and Santa Clara, median household income in 2022 was between $136,000 and $150,000. Statewide, median household income was $85,300, while some counties have median incomes between $50,000 and $70,000. Unsurprisingly, hospitals in the above three Bay Area counties have correspondingly high costs, and the opposite is true where household incomes are lower. This tight relationship between hospital labor costs and median household income is shown in the figure to the right, which demonstrates that the need to provide competitive salaries drives differences in hospitals' labor costs.



Higher Cost of Living Is Similarly Tied to Higher Hospital Costs. As with incomes, cost of living is anything but

homogenous across California. According to a measure called the regional price parity index, a $200 doctor's visit, restaurant meal, or purchase from a local home goods store in San Francisco could be expected to cost $170 in the Eastern Counties or $191 in Los Angeles. Regional cost of living is closely tied to the local wage levels, real estate prices, and the prices of other necessities and amenities. As expected, hospital expenses track differences in the cost of living throughout California. For every 1% increase in the cost of living for a given region, the cost to provide hospital services increases by around 4%. Predictably, cost of living ties most closely to hospitals' labor expenses, which are determined by local labor market conditions far more than, for example, hospitals' supply costs (including pharmaceuticals), which are more influenced by national pricing trends.

Conclusion

Hospital spending varies significantly throughout the state, whether viewed on a per-capita or per-service basis. This is driven by varying population health needs, as well as differences in the cost of living and the price of attracting a highly skilled and increasingly scarce workforce. Higher reimbursement is not a simple matter of hospitals charging and earning more. Ultimately, this analysis reveals that structural issues related to health needs and the cost of providing care must be explored as OHCA seeks to improve health care affordability for all Californians.

Sincerely,

Ben Johnson
Vice President, Policy

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